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ABSTRACT

This document provides the transcripts from the Congressional hearings on the Older Americans Health Education and Training Act. This act is to provide the necessary resources, leadership, and coordination: (1) to design a uniform, standardized program of health education and training for older Americans; (2) to directly involve educational institutions of public health in the design and implementation of the program; (3) to implement the program throughout the country in multipurpose senior centers established by this Act; and (4) to evaluate the program. Opening statements from Representatives Ike Andrews and Carl Perkins are presented. Testimony is presented from 37 professionals, including professors and deans of medical schools, community health, and public health; legislative consultants representing retired persons; and directors and secretaries of government and private programs. Several pamphlets, letters, and supplemental materials are included, covering topics concerning the emotional and physical health of the elderly, and promoting unique programs to serve this population. The appendix contains numerous statements, letters, and newspaper articles dealing with issues and services pertaining to the elderly. (BH)

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OLDER AMERICANS HEALTH EDUCATION AND TRAINING ACT

ED252773

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON EDUCATION AND LABOR
HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

FIRST AND SECOND SESSIONS

ON

H.R. 4472

TO AMEND THE OLDER AMERICANS ACT OF 1965 BY ADDING A NEW TITLE RELATING TO MULTIPURPOSE SENIOR CENTERS EDUCATION AND TRAINING

HEARINGS HELD IN CHAPEL HILL, NC, ON DECEMBER 20, 1983, AND WASHINGTON, DC, ON MARCH 28, 1984

Printed for the use of the Committee on Education and Labor

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OLDER AMERICANS HEALTH EDUCATION AND TRAINING ACT

TUESDAY, DECEMBER 20, 1983

HOUSE OF REPRESENTATIVES,
COMMITTEE ON EDUCATION AND LABOR,
SUBCOMMITTEE ON HUMAN RESOURCES,
Chapel Hill, NC.

The subcommittee met, pursuant to call, at 10:30 a.m., in the conference room, General Administration Building, University of North Carolina at Chapel Hill, NC, Hon. Ike Andrews presiding.

Members present: Representatives Andrews and Perkins.

Staff present: Gordon A. Raley, staff director, Deborah L. Hall, clerk; and John E. Dean, Republican assistant counsel.

[Text of H.R. 4472 follows:]

[H.R. 4472, 98th Cong., 1st Sess.]

A BILL To amend the Older Americans Act of 1965 by adding a new title relating to multipurpose senior centers education and training

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the Older Americans Act of 1965 (42 U.S.C. 3001, et seq.) is amended by adding at the end a new title as follows:

"TITLE VII—OLDER AMERICANS PERSONAL WELFARE EDUCATION AND TRAINING PROGRAM

"SHORT TITLE

"SEC. 701. This title may be cited as the 'Older Americans Personal Welfare Education and Training Act'.

"FINDINGS

"SEC. 702. The Congress hereby finds that—

"(1) persons 60 years of age and older constitute the fastest growing segment of the Nation's population;

"(2) the process of aging, as well as the changes in lifestyle which accompany it, such as retirement, the end of parenting roles, and relocation, seems to increase and exacerbate health problems faced by the elderly (such "health problems" include physical, mental, and emotional health problems);

"(3) many of the health problems faced by persons 60 years of age and older, such as arteriosclerosis, arthritis, adult-onset diabetes, hypothermia, heat stress, Alzheimer's disease, circulatory problems, hypertension, diminished hearing and eyesight, reduced strength, social isolation, and bone fragility are particularly common to the older American population;

"(4) although the elderly make up only 11 percent of our population, they consume 29 percent of the total health care expenditures and 50.5 percent of Federal health care (non-military) expenditures, and as our population ages the percent of Federal health care dollars absorbed by the elderly will inevitably increase;

"(5) the elderly consume more prescription and over-the-counter drugs than any other group and are therefore more likely to be exposed to drug preparations containing two or more active drugs which negatively interact;

"(6) many of the health problems faced by older Americans and the fear of those health problems can be ameliorated and in some cases prevented if proper health education and training is available;

"(7) health education and training focused specifically on the needs of older Americans can play an important role in health promotion and illness prevention while, at the same time, helping to reduce medical costs for both individuals and Government;

"(8) the educational institutions of public health have much to offer in the design and implementation of health education and training services for older Americans; and

"(9) the existing 3,300 multipurpose senior centers established by this Act, as amended, which already serve over 9,000,000 older Americans each year, are appropriate points of contact from which health education and training can be provided, but there is currently no uniform, standardized program consistently in place across the Nation.

"PURPOSE

"SEC. 703. It is the purpose of this Act to provide the necessary resources, leadership, and coordination (1) to design a uniform, standardized program of health education and training for older Americans; (2) to directly involve educational institutions of public health in the design and implementation of such program; (3) to implement such program throughout the country in multipurpose senior centers established by this Act, as amended; and (4) to evaluate such program.

"OLDER AMERICANS PERSONAL WELFARE EDUCATION AND TRAINING PROGRAM

"SEC. 704. (a) In order to foster and promote the design and implementation of a health education and training program for older Americans who are 60 years of age or older, the Secretary of Health and Human Services (hereinafter in this title referred to as the 'Secretary') shall establish an older Americans personal welfare education and training program.

"(b)(1) In order to carry out the provisions of this title, the Secretary shall enter into agreements with public or private institutions of higher education with capability in public health in order to further the purposes of this title. No payment shall be made by the Secretary toward the cost of any project established or administered by any such institution unless the Secretary determines that such project—

"(A) will provide for the design and implementation of a local or statewide demonstration health education and training program which is amenable to eventual replication in multipurpose senior centers throughout the Nation;

"(B) will provide for coordination with multipurpose senior centers established pursuant to section 321(b)(1) of this Act with regard to both the design and the provision of services;

"(C) will be generally applicable to the health needs of all persons aged 60 or over;

"(D) will provide for the development of uniform, standardized components aimed at specific problems encountered by the elderly, such as diet, mental health, hypertension, retirement, health insurance, and hypothermia;

"(E) will provide education in the safe and effective use of prescription and nonprescription medicines;

"(F) will address the motivation of individuals including consideration of the elements of self-responsibility, physical fitness, stress management, nutrition, and environmental awareness; and the benefits the elderly can derive from behavioral and lifestyle modifications within individual control;

"(G) will provide for peer contact and interaction among participating older Americans;

"(H) will provide for the training and utilization of graduate students and faculty in public health and the medical sciences, volunteers, and older American participants themselves;

"(I) will insure that participating older Americans are made aware of the health services available to them in their communities; and

"(J) will be supervised by persons specifically competent in the field of public health.

"(2) The Secretary shall establish, issue, and amend such regulations as may be necessary to effectively carry out the provisions of this title.

"(c)(1) The Secretary shall pay not to exceed 90 percent of the cost of any project which is the subject of an agreement entered into under subsection (b).

"(2) The non-Federal share shall be in cash or in-kind. In determining the amount of the non-Federal share, the Secretary is authorized to attribute fair-market value to services and facilities contributed from non-Federal sources.

"(d) The Secretary shall prepare and submit to the Congress, not later than one year after the enactment of the Older Americans Personal Welfare Education and Training Act, an interim report describing the projects approved under subsection (b) and a design for the evaluation of those projects. The Secretary shall prepare and submit to the President and Congress a final report on the projects approved under subsection (b) not later than February 1, 1987, along with such findings and recommendations as the Secretary deems appropriate.

"ADMINISTRATION

"SEC. 704. (a) In carrying out the provisions of this title, the Secretary is authorized to use, with their consent, the services, equipment, personnel, and facilities of Federal and other agencies with or without reimbursement, and on a similar basis to cooperate with other public and private agencies and instrumentalities in the use of services, equipment, and facilities.

"(b) Payments under this title may be made in advance or by way of reimbursement and in such installments as the Secretary may determine.

"(c) The Secretary shall not delegate any function of the Secretary under this title to any other department or agency of the Federal Government.

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 705. (a) There is authorized to be appropriated such sums as may be necessary to carry out this title for fiscal years 1985, 1986, and 1987.

"(b) Amounts appropriated under this section for any fiscal year may remain available for obligation until expended.".

OPENING STATEMENT OF HON. IKE ANDREWS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH CAROLINA AND CHAIRMAN, SUBCOMMITTEE ON HUMAN RESOURCES

Mr. ANDREWS. Good morning, ladies and gentlemen. Let me ask you to all have a seat. We'll call to order this hearing before the Subcommittee on Human Resources, it being one of the eight subcommittees of the House Committee on Education and Labor.

Certainly, it's a pleasure to be here. In order to maximize our time together, I'll keep my remarks quite brief. I'm sure all of you know that we are here with respect to the consideration of H.R. 4472, which I introduced some short time ago, and in which, I hope, all of us have considerable interest.

Let me say just briefly, that all of us know the purpose of the bill. What I've introduced is no more than the framework of an idea. I think that it is a good idea, but I, by no means, presume to have it finalized. It's a skeletal concept about which I have some particular ideas but about which I also remain, for the most part, quite openminded. It is really two or three concepts, in fact, that I think should perhaps best be put together. But surely we have not finalized any of the particulars. As I like to think of it, we need, for the purposes intended, teachers, classrooms, course material, and students, basically. Now, just who should be which, from whence should they come, of what should the course material consist, I obviously don't know yet, in any definitive way. For all of those purposes, we need suggestions, and we welcome any that we might receive today.

In that spirit, we will ask that the hearing come to order. Let me briefly, if I may, introduce three of our staff people here. If you

don't know them I hope you will. If you are interested in the work of our subcommittee or the full Committee on Education and Labor, you should.

Mr. Gordon Raley is on my left, and he is the staff director on the subcommittee, and Mrs. Deborah Hall—with the blue blouse—they flew down from Washington yesterday.

Mr. John Dean on my far right represents the minority staff and is a good friend. We don't work like adversaries at all; we work as friends of the programs that are within the jurisdiction of the subcommittee, which are many, important, and for the most part, certainly good programs.

From our Fourth District office we have Mrs. Betsy Ann Reavis and you should know her in another respect. She is in your district office. We soon hope to have one opened in Chapel Hill, incidentally. If we get away from here in time I'm going to look at a prospective office here, but for now, at least, those of you who are from our congressional district are served basically by the office in Cary, and Mrs. Reavis is there on a full-time basis. She is not related to the subcommittee or the committee, but rather to the Fourth District congressional office.

Most of all, Gordon, with due respect to you and John and the others, I'm especially pleased to have, to my immediate right, not only one of the most outstanding and distinguished Members of the U.S. House of Representatives, but of all Americans as well. Chairman Carl Perkins has been my chairman since the day I was sworn in back in January 1973. Largely because of President Bill Friday, I sought and was very pleased to be appointed to the Committee on Education and Labor. Chairman Perkins helped accomplish that with the Speaker and the nominating committee and it has been a distinct pleasure and honor for me to serve as a member of his committee, and, now, for some 6 years, as one of his subcommittee chairmen. You could not work for a greater person, one who is easy to work for and who is always encouraging. He is an outstanding fighter for the poor, for education, for health, for fuel for the needy, for housing, whatever helps make life better for millions and millions of Americans. He has done so in the Congress for 30-odd years—I don't even recall how many.

I know he gets up early because he got up early in Kentucky this morning and met me here, and I came from Cary. It's somewhat embarrassing, but the truth is the truth. Certainly, we welcome you here, Mr. Chairman. Do you have any remarks as we open the hearing?

OPENING STATEMENT OF HON. CARL D. PERKINS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KENTUCKY AND CHAIRMAN, COMMITTEE ON EDUCATION AND LABOR

Chairman PERKINS. Yes, Mr. Andrews. First, let me state that it is a great pleasure for me to be here. You know, I came in 1974 for a hearing, on nutrition and student assistance programs. Congressman Andrews commenced on that back in 1973, the first year that he was in Congress. I kept telling him that I would come, but I never got to come until about a month before the primary election. Then when I came down here, I met all of the reporters, and they

thought it was political. I said that it wasn't political at all since, that I was the one that was responsible for not going when I should have gone earlier in the year. If it had been the day before the election, after I made the commitment to Mr. Andrews, I would have been here just the same. It was every word the truth. The reason I came was that Mr. Andrews had demonstrated to all Americans that he is an outstanding Congressman, he has helped broaden all of the Student Assistance Programs, worked on the School Lunch Program over a period of years, worked on the legislation for the elderly over a period of years, and I feel that I would be derelict in responsibility if I didn't show up at this hearing today.

This idea is Congressman Andrews' idea about better nutrition programs for the elderly, about lowering the medicare costs and medicaid costs, and the health costs to the elderly. Naturally that can be done through preventative medicine, or programs and lecturing by people who are qualified to participate in those lectures. But the beauty about this program that Congressman Andrews is advocating is that it's going to cost so little money, practically nil. And I think that in itself demonstrates the type of Congressman that you have representing you. He has worked so diligently in the legislature for the elderly and the Older Americans Act. We all look to Ike Andrews for our leadership in that whole area.

He has done an outstanding job, and I think that this bill he is sponsoring here will sail through the U.S. Congress. As he stated, this is not the final product, by any means that he has offered here, and that you are going to testify about. We all know something about the high medical costs taking place throughout the country today, and it is our responsibility and duty to do everything possible to reduce that cost. There are preventative ways that people understand—knowing the right foods to eat, the proper nourishment and that sort of thing—and that's really something that a lot of us are careless about. These people who can instruct the elderly in these community centers throughout the country, the trained health professionals, will be getting salaries anyway, and it will be very little cost to ask them to make trips to these senior citizens places to give instruction. It's one of the most beneficial ideas, I think, that I've witnessed in the Congress, and one of the most innovative ideas. It's not a complex idea. It's a simple idea, and it should have been done perhaps long before now, but nobody thought about it except your own Congressman, Congressman Andrews.

I've seen us work on nutrition programs, food stamps, and the School Lunch Program, I've been working on the School Lunch Program since 1949, and we'd had perhaps, during that period of time, 40 or 50 studies made about better nutrition and so forth for the children throughout the country. But we are late about getting started in this area, and let me say that I want to compliment Congressman Andrews for coming up with this legislation, and assure you people that he will have my wholehearted support in the passage of this legislation. There is no doubt in my mind that the legislation will sail through the House of Representatives, just like a ship sailing through waters that are free to the world. I think he deserves a lot of respect for offering this piece of legislation that is

not costing the Government, as you will see, any money, and is going to mean so much not only to the elderly, but in saving money for the United States of America.

Mr. ANDREWS. Thank you very kindly, Mr. Chairman, I appreciate those words. First, we are pleased to have the dean of the School of Medicine, University of North Carolina at Chapel Hill, Dr. Stuart Bondurant, and we welcome you very kindly, sir. You are the essence of what we are looking for. We appreciate your presence and look forward to your statement.

If you have a written statement, Dean, and I say this to everyone, we hope you will submit it for the record. Without objection, all such written statements will be received and entered into the record. Then you are free to either read your statement; paraphrase it; or, put it in the record and then speak off the cuff, as you choose.

[Prepared statement of Dr. Stuart Bondurant follows:]

PREPARED STATEMENT OF STUART BONDURANT, M.D.

Chairman Andrews, it is a great personal pleasure for me to welcome you and Congressman Perkins and your associates to the University of North Carolina on behalf of President Friday who cannot join us today because of a long-standing prior commitment in another part of the state and on behalf of Chancellor Christopher Fordham and all others in the faculty and administration of the University of North Carolina System. We are all the beneficiaries of your important contributions to higher education in the United States and most especially for your contributions to the University of North Carolina and through it to the people of the state of North Carolina.

Under the leadership of Mr. Ernest Messer and Secretary of Human Resources Dr. Sarah Morrow and many other thoughtful and active leaders in the state of North Carolina and in association with many elements of the University of North Carolina we are working diligently to improve the quality of life of our growing population of older North Carolinians. We are working on many fronts because there needs to be serious and effective consideration of several categories of special needs of our older citizens including for example, housing, transportation, financial needs, social needs, and, of course, health needs. In many ways the health needs are fundamental because the burden of illness or poor health falls particularly heavily upon the elderly population because the elderly often have fewer means of adaptation or accommodation either socially or physically. From this observation in part, rose the great importance and urgency of the provisions of your bill H.R. 4472, "The Older Americans Personal Welfare Education and Training Act."

This bill, which clearly draws upon your long-standing commitment to support programs for the benefit of older Americans and which reflects your personal experience and wisdom offers immense promise of potential benefit to the health of older Americans by virtue of its sound and appropriate emphasis on health promotion and disease prevention through personal education. We join enthusiastically in this approach for improving the health of young and old and especially for improving the health of older Americans. Your idea that we use senior centers as sites for education in health promotion and disease prevention is powerful and innovative. As you know, the state of North Carolina has, through the Area Health Education Centers, and experience which is unique in the entire nation in the dispersal of health education through the state. While these educational program are directed principally toward health care providers, the experiences of a decade let us conclude that the principle is sound and workable provided that the programs themselves are realistically designed to relate to the local communities and the needs of the individuals involved and are carefully and continuously evaluated against some standard of effectiveness expressed in terms of health outcomes.

I would like to offer three suggestions for consideration by the panel and by the committee.

First, I would suggest that the educational programs be designed to articulate with the health care delivery system in the community being served in order that the educational program can be appropriately informed of the health burdens of that community so as to assure relevance of the educational programs to the people

being served and to allow the educational programs to draw upon the rich array of public health educational potential which is contained within the many health care disciplines in the local communities.

Second, I would recommend that, for purposes of program implementation, it be made the clear intent of Congress that the many different health care disciplines proficient in appropriate health education be eligible to serve in an educational capacity for the purposes of this program according to the special needs and opportunities in each center.

Third, because there is no actual basis of experience in the design of a nationwide system of health education based in the senior centers, I strongly support the plan to begin with pilot and demonstration projects according to the language of the bill. I would suggest that in implementation of the bill demonstration projects should be mounted only after the demonstrated success of pilot projects of the same type. This suggestion is based upon the observation that the design and operation of a successful pilot project does not guarantee the ability to replicate the project in the demonstration mode. Accordingly, I would hope that the bill would allow the support of both pilot projects and demonstration projects sequenced to assure an ultimate national network.

Chairman Andrews, I want to thank you again for the great initiative represented by H.R. 4472 and for your personal contribution to that initiative. I share the judgement that older Americans throughout the nation and especially in North Carolina will find great benefit as a result of your bill. I thank you for the opportunity to participate.

STATEMENT OF DR. STUART BONDURANT, DEAN OF THE SCHOOL OF MEDICINE, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

Dr. BONDURANT. Thank you very much, Mr. Chairman. I'll probably do a little bit of both, if that's all right with you. I first of all want to express my personal pleasure in welcoming you and Chairman Perkins to the University of North Carolina, both personally and on behalf of President Friday who was, unfortunately, as I think you know, detained in another part of the State today on long standing prior university business that no one else could fulfill. And I can assure you that that is the only reason he is not with us this morning, and I'm here to extend that welcome on his behalf, and also on behalf of Chancellor Christopher Fordham who, as you know, has a background of some substantial interest in the field of this legislation. And who, I am sure, were it possible, would also wish to welcome both of you to the University for the purposes of this hearing.

Our welcome is a particularly warm one, again to both of you, because of all that you two have meant to education in the United States for such a long, long time.

I want to make a personal and institutional expression of appreciation to both of you for your great contributions to education in the United States. And especially, Congressman Andrews, from the University of North Carolina, both before and after your election to the Congress of the United States, and through that university to the people of North Carolina. We've labored in the same vineyards for a long time, and we thank you for your leadership and your contributions.

Add to that the fact that the Kentucky basketball team is rated No. 2 in one poll and the North Carolina team is rated No. 1 in that one, the right poll—and another poll made a small error—that makes an even more interesting time to have a chance to visit. I think in an ecumenical spirit perhaps we can say that between us we have basketball pretty well covered in the United States.

I would like to turn now to the very important, exciting and serious subject of these hearings, and say by way of background that under the leadership of Mr. Ernest Messer, who will be following me on this program, and the Secretary of Human Resources, Dr. Sarah Morrow, Dr. Ibrahim, and Dr. Cohen, and many other thoughtful and active leaders in the State of North Carolina, and in association with any elements of the educational system of the State of North Carolina, and I purposefully include the entire system of education, notably including the school of public health, the four great medical schools in the State, two public sector and two private sector medical schools, schools of nursing throughout the State, programs and school of allied health instruction, along with many citizens groups devoted to the interests of the elderly citizens of North Carolina,

We have been working diligently for some time to improve the quality of life of our growing population of older North Carolinians. We're a little bit ahead of the rest of the country, in fact, in the rate of growth of the proportion of our older citizens, owing, we think, to the attractiveness of our situation, said with all due modesty.

We are working on many fronts on these because there needs to be serious and effective consideration of several categories of special needs of our older citizens, including, for example, housing, transportation, financial needs, social needs, and of course, health needs. And the reason I mention this at the outset is to say that while I'm going to focus in on the health needs that are so importantly a part of this bill, I'd like for it to be known that we in North Carolina are working diligently on this whole spectrum of needs of our elderly citizens, but in many ways the health needs are fundamental because the burden of illness rests particularly heavily on the older citizens, in part because they often lack the flexibility and the adaptability, both physically and socially, that other citizens have. And so a little bit of advantage in the health care of the elderly can make a great difference in their lives. I speak now as a clinician who has spent many years in the care of patients.

And of course it's from this observation, in part, that rose the great importance and the great urgency of your bill, H.R. 4472, the Older Americans Personal Welfare, Education and Training Act.

Mr. Andrews, it seems to me that this bill clearly draws on your longstanding commitment to programs for the benefit of older Americans, and also to educational programs. We think that it offers immense promise of potential benefit to the older Americans' health by virtue of its sound and appropriate emphasis on health promotion and disease prevention through personal education. We join enthusiastically in this approach for improving the health of all Americans, young and old, but most especially for improving the health of older Americans.

Your idea, to use senior citizens centers as sites for education and health promotion and disease prevention as pointed out by Chairman Perkins, is an ingenious and powerful idea. It's interesting to reflect, I think; as you know, the State of North Carolina has, through the area health education centers, had an experience that is unique in the whole country in the dispersal of health edu-

cation throughout the State. There are other area health education centers in other States including Kentucky around the country, but ours is the most comprehensive one, I think, by general consensus, that exists.

This experience gives us, and this has been in operation for a decade, and so on the basis of a decade's experience we can bear witness to the effectiveness of the dispersal of health education throughout the State. Now, this program draws upon the four medical schools of the State, it draws extensively upon the school of public health, the nursing schools are involved, the allied health schools are involved. It is aimed primarily at the education of health care providers, but through them and through satellites around each of these individual health education centers there is an immense volume of personal health education that goes on as a result of these educational programs.

Well, this decade of experience leads us to conclude that the principle of dispersal of health education throughout the system, as is considered in your idea, is sound and workable. There are important considerations. One is that we believe the programs need to be realistically designed to relate to the local communities in which they are housed. The participants in the local communities need to be able to be involved in that. And second, it's important to be able to measure the outcome of these programs, and measure the outcome not only in terms of process, but in terms of the effect of the process; to be able to observe what differences the programs make as a way of being sure that they are, in fact, being effective, or changing them to address another matter if the one that's there is not effective.

I would like to offer three suggestions for consideration by the panel to follow, and perhaps by the committee if these suggestions seem to have merit in the eyes of the committee. First I'd like to suggest that the educational programs in the senior citizens centers be designed to articulate in some way with the health care delivery system in the individual communities. The reason I offer this suggestion is—there are two reasons; one is because the health care needs differ in different communities across this great and diverse country, and so these local programs should take into consideration the particular health care needs of the individual community in which they serve. They can do this, I think, best if they have some relationship to the health care delivery system of that community so they know what are the health care problems of that community. This also will enhance the ability to evaluate the effectiveness of the programs, of the educational programs, because the health care delivery people will be able to say what differences are occurring as a result of the programs.

Second, I would recommend that for purposes of program implementation, the point that you made earlier, Mr. Andrews, that many health care providers be involved in the educational process is, I think, key to the success of the program. There is an immense amount of competence in education for health needs that resides in many of the communities, and many different types of health care providers can be called upon, I think, for the benefit of the program.

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And the third suggestion draws on the fact that this is, part of the attraction of this idea is its power, it's global nature, it's an opportunity to influence the health of older citizens all over the entire country. But at the same time it's exciting it's a humbling kind of a consideration because it's never been done before. No one has ever designed that broad a network, and it seems to me that for that reason it would be very important to build in concrete and brick, and to build on the basis of actual experience from individual units multiplying.

Now, the language of the bill, I think, clearly calls for this, so I'm really only expressing agreement with the language that is in the bill as it stands now.

I would encourage the development, first of all, of what I will call for these purposes pilot programs, and that language is used, of course, in the bill—pilot programs in which a concept of education would be tested in a setting like that in which it will be exercised. But it seems to me that even if a pilot program is proven to be successful it's another matter to insert that into a series of different kinds of communities, and therefore there is virtue to having a demonstration program in addition to a pilot program.

The pilot program tests the theory of education, and the demonstration program tests what is involved in putting it in place in an individual community which may, to some extent, be different.

It seems to me that if those two steps were put in place that then one could be very confident when spreading this on a national scale; that it would be an effective and workable program.

Those are the three suggestions that I would like to offer. I would like to close by thanking you again for the great initiative which is represented in this bill, and for your personal contribution to that initiative. I believe that older Americans throughout the Nation, and especially in North Carolina, will find great benefit as a result of the bill, and I thank you very much for the opportunity to attest to that.

I will, of course, be glad to answer any questions, if I can be helpful to you in any way, now or later.

Mr. ANDREWS. You certainly already have been, and we'll be calling on you, I'm sure, not only today but as time goes on.

There's going to be a temptation for me today—and I'm going to try to resist it as best I can—to do a lot of reminiscing being where I am. I can recall being here for the dedication of this building, and on and on it goes.

Let me just say that the general public's comprehension of medicine, as part of the field of education, relating to other than its own students is, in my opinion, relatively new. You mentioned Chris Fordham, I remember well that I was chairman of the chancellor selection committee here when Carlyle Sitterson resigned. I was just thinking that I don't believe that anyone from the school of medicine or the allied health fields was even nominated among the more than 100 that were nominated for chancellor at that time. Certainly, no one from the field of medicine was among the some 5 to 10 who were finalists. I dare say you could go back and find that the school of medicine was, until relatively recently, in my opinion, not really considered a part of public education. It was a school over there to teach health professionals to deliver a service. That

service was highly valued, obviously, and has been through the eons of time, but I don't think the school was ever thought of as being a teacher beyond teaching those who, in fact, would practice.

So it's a real innovation, I think, to find that the University of North Carolina and other great universities and schools of medicine as well as allied schools of public health, social and nursing are reaching out to educate others work in the community. That's a real innovation here.

As to the substance of your comments, dean, I appreciate your compliments of the idea. I am very excited about it in a general way. A lot of the specifics are going to be difficult, and you've alluded to some of them.

Perhaps one of the most difficult aspects is going to be that this will be, if it should be adopted as law, a Federal initiative. As such, there is the fine tuning that's quite difficult between trying to accomplish an overall public purpose to assist the elderly and while, at the same time, keeping the Congress and whatever bureaucracies might become involved out of the business of dictating to institutions of higher education who should do what—in other words, protecting academic freedom.

I'm aware of both and in sympathy with both goals. I am aware that there is a certain danger when we start legislating from Washington what professors, graduate students, and others in this and other institutions of higher learning which resources should be tapped from the classroom or the laboratory to go to Durham or Burlington—who should go; what they should do when they get there; what they should come back with; to what extent they should evaluate; who should do it; to whom should they report? Does the work remain part of an academic effort as such, or does it become part of a Federal and then public examination of what's being done on the campus, hence bringing in a lot of perhaps unwanted, and in some instances, maybe unproductive activity so far as the basic mission of the institution of education and its various departments are concerned.

I am aware that that could be a problem. We want to do all we can to resolve that potential problem in terms of the benefits that might accrue and I think there will be benefits. I think the Nation as a whole, and certainly the elderly, can benefit tremendously from this information, expertise, energy, and interest that, thus far, has been substantially confined to the laboratories, library shelves, or minds of people within these institutions. I think it's great to get the information out.

I think senior centers can serve as a laboratory for you too, yes, to demonstrate and evaluate and improve your teaching ability. I think it can enhance the institution of higher education, but I am aware of that danger.

Certainly, I agree with you that local needs come first. On the other hand, in order to be sure that the taxpayer gets some minimum quality in the curriculum to be offered, we need some minimum standard, some standards. We don't need, I know, to teach older people about protection from the cold in south Florida, but you do in Maine, so their needs do, indeed, vary from place to place.

I'm concerned, with cost but I think we can do it all without spending a lot of money, Mr Chairman. Couldn't we teach better if the teacher better knew the composition of each class in terms of how many of them have greater danger from high blood pressure or from some spinal disorder, or whatever. So who do we use? How do we go into this class of however many, 50, 70, 100, however many happen to be at each place? Do we get their medical records, or do our own examination of them, or just how do we let the teacher, when he or she does come there, know what the composition is in terms of their specific problems so as to know whether to emphasize diets or back exercises, or whatever.

It is quite a task, and we're going to need a lot of help to come up with a bill that's tight enough to get the job done for the elderly, but is not overly restrictive or one which constitutes too much of an invasion of the academic institutions or the community at large, if you please. So how are we to fine tune the bill, or do we rather draft as is usually done, a very general bill and leave it up to the Secretary of HHS, or her successor or some appointed commission for refinement?

To what extent do we involve State agencies, or should this rather be run out of the regional offices such as Atlanta? Should we even address that in legislation itself? All of these are going to be knotty and political problems. I just hope we can start now by asking everybody to cooperate, not so much for the function which we represent, but rather instead for all purposes of the intended legislation. I would thank you for being the first witness to get us off on the right foot with respect to these questions. They are just examples of the various problems we will have. Thank you so much.

Mr. Chairman, do you have any questions?

Chairman PERKINS. Yes. Dean, I would like to ask you one question. I know we have several witnesses here this morning, but I would think that you have had considerable experience in this area and knowledge of what has taken place here in your home State regarding the availability of the health care professionals throughout the State, and where they are trained. Do you feel that we could get these health professionals into these senior citizens centers throughout the country with very little cost to the U.S. Government? Go ahead and explain that. Give us your views on that. How you would suggest that we enact legislation along that line.

Dr. BONDURANT. Well, I think my bottom-line answer to your question is yes, but I would say that very little cost is relatively very little cost, and not necessarily absolutely very little cost, because I think there will be some cost involved in doing it right. I believe that, as I said in my earlier comments, that there are, in many communities of the Nation, people who have the potential to serve this function well. And as you pointed out in your comments, they are available in the communities and they are interested in and devoted to the communities, and I think it can be organized at a very, very low-cost level. But I do believe there will be some costs of organization and some costs of setting standards and of validating the standards that take place, as Congressman Andrews pointed out in his comments as well.

I suspect also that there will be some costs that will, some categories of staff persons for the program that will have to be met, whether they are at the regional level or at the local level. So that while I share the enthusiasm for the potential of doing something at very low cost, I would hope that it would be funded well enough to assure a first-rate job being done, and I suspect for that purpose there will be some cost.

I do think that the cost can be so small in relation to the benefit that it would be imprudent not to take advantage of the savings that would be represented, provided the programs are designed very carefully to improve the health of the elderly, and thereby realize the savings.

So I guess I'm giving a positive answer to your question, but those are the considerations that I would have in mind, some of the considerations, as I tried to design the costing of the program.

Chairman PERKINS. Now, let's consider in this area the availability of personnel to instruct, to lecture and to serve the senior citizens. Of course, you may be better equipped in this area than we happen to be in the rest of the Nation; however, limiting your remarks to this area, do you feel that we have adequate health professionals already trained, and that we could use health professionals that are being trained through vocational schools and other allied centers throughout the Nation? Give me your views along that line.

Dr. BONDURANT. Well, I wish I could give you a crisp and definitive answer. My view is both a yes and a no in a way. I think we have a huge reservoir of people who can potentially be used very, very effectively in this capacity. Many of them will require some added guidance if not training in order to be effective, and I think that would be one of the costs that I would anticipate being involved in some way in the program.

On the other hand, I doubt myself that there are enough people in the Nation presently trained to be able to carry this program out. So that my own judgement is that one component of the program in the long run should be a conscious and purposeful effort to train an additional group of people to fulfill these responsibilities. I don't, as I said earlier, I would not design the program so that they were the only ones who were in it. I would not set out to create a whole new group of teachers just to teach for this program. In fact, I would have that, a small minority. I would design it to try to draw in large numbers of other people.

Chairman PERKINS. Now, if you were designing the program, would you work closely with the county health departments and the city health departments throughout the Nation; and to what extent would you feel that they could serve the senior citizens?

Dr. BONDURANT. My impression, and Dean Ibrahim would be in a better position, I'm sure, to comment on this than I am, but my impression from my own observations is that there is considerable variation in the effectiveness of State health departments and county health departments in these special areas across the Nation. They aren't all equally strong, experienced, or devoted. But if you remember, one of my recommendations was that this program should articulate with the health care delivery system, and the health departments were one element of the health care deliv-

ery system that I had in mind as a very important source of support and interaction with this program.

So I think there needs to be some recognition that all health departments aren't alike, and that they aren't all equally capable to assist in the program, but that many many of them would be a powerful and effective asset to the program, and that all of them should be purposefully involved, I think, in the design and operation of the program.

I believe the same should be true of the county medical society, or the dental society, the nurses associations, the public health nurses associations and many other bodies that in each community have a very good sense of what that community's health needs are, and can be a source of informing the educational programs.

Chairman PERKINS. Mr. Dean, do you want to ask any questions?

Mr. DEAN. I just have one question. Some areas of the country are not served by institutions of higher learning capable of fulfilling this function, would you suggest that the legislation be broadened to include grants to hospitals, where appropriate, so that services could be nationwide.

Dr. BONDURANT. I hadn't thought about that question until this very moment, and it's not a simple question. I suppose I'm a little reluctant to answer it without more reflection. It is a difficult question.

I'm influenced in part by the fact that while there are 7,000 hospitals in the country there are only about 400 of those that are teaching hospitals, and that means that the vast majority of hospitals have not had the machinery of education in place. That's not been an important part of their corporate purpose, or their institutional purpose, and because of the newness of this kind of approach I would be sort of reluctant to turn to where there is nothing in place to sort of implement the program. And perhaps that observation tilts me toward wondering if there is not some way to put together consortia of educational enterprise. In every State there is, of course, a department of education and a department of health, and there are links between them in every State of some kind at least, and I would wonder about going more in that direction, perhaps building it into the hospitals in some way in the community rather than having the management, the administrative element be based in a hospital which is not traditionally devoted to education.

Mr. DEAN. Thank you very much.

Dr. BONDURANT. Mr. Chairman, if I may offer one more comment, which I think will please you because of your own contributions to primary and secondary education in the United States. Mr. Andrews' comments, which indicated the fact that medical schools have now become interested in their physicians being teachers. Schools of public health, you know, have had a long experience in educating health educators, but I think that medical schools in this country were very slow to come to the idea that doctors needed to be teachers as well as prescribers.

I think you might enjoy knowing that we, among other medical schools in the country, have now recruited schoolteachers from our schools to instruct our medical students as to how they can best instruct their students; so that we are now a beneficiary of the edu-

cational programs that in earlier years you and your colleagues sponsored. These are now helping us to teach doctors to teach, and we thank you for that as well.

Chairman PERKINS. That's very interesting. Thank you very much for your excellent testimony.

Your next witness is Dr. Sarah T. Morrow, secretary of the North Carolina Department of Human Resources, Raleigh. We are delighted to welcome you here, and you may go ahead.

[Prepared statement of Dr. Sarah T. Morrow follows:]

PREPARED STATEMENT OF SARAH T. MORROW, M.D., M.P.H., SECRETARY, NORTH CAROLINA DEPARTMENT OF HUMAN RESOURCES

Mr. Chairman, members of this subcommittee, ladies and gentlemen. I am happy to appear before you today in support of H.R. 4472. I believe that health education for our older citizens has become essential in this changing society.

Senior citizens today face the prospect of living longer than ever before. Those years can be happy, productive years if one has good health. On the other hand those extra years can be plagued with debilitating illness and rising medical bills.

Our good health depends on the way we live and the way we take care of ourselves. So many elderly people don't know how to stay healthy. That lack of knowledge costs them in terms or discomfort, as well as dollars.

And it costs every other American taxpayer too. In 1982, while the Consumer Price Index for all items went up 3.9 percent, the cost of health care grew by 11 percent. We cannot afford to have our third largest industry growing at more than twice the rate of the rest of the economy.

Medicaid costs are equally disturbing. Last year in North Carolina, medicaid payments rose 10 percent, to over 539 million dollars. 39.6 percent of those payments were for the elderly. The age group that this proposed legislation would help is the very group that takes the largest chunk of the medicaid budget.

Prevention of health problems is an important part of the solution to cost. A key to prevention is health education. It can make a difference not only in whether our elderly are healthy or ill. It can also affect the degree of illness and lessen the severity of many problems. Here again, we are talking dollars—the difference between a condition that can be treated at home or one that requires institutional care. In November 1983, medicaid in North Carolina paid $1,069 per person for nursing home care and only $323 per person for in-home care.

Although this figure for in-home care does not include the cost of upkeep on the home and other personal expenses, it is still significant. Clearly both our elderly and our economy benefit from in-home care. Physically and psychologically, the elderly are better off in their own homes.

There is another important reason why we must take responsibility for teaching our older people to maintain a healthy lifestyle. Often, there is no one else to do it. The tradition of families caring for their own elderly is fading fast. No longer can we assume that a younger relative is in the home watching out for diet and medication. The trend toward living away from one's family is growing, and it's growing faster in North Carolina than in the rest of the Nation.

In 1970, just under 16 percent of our older people were living with relatives. By 1980, that figure was just under 10 percent, a drop of nearly six percent. During the same years, the national rate dropped by about three and one-half percent.

We can no longer count on other family members in the home to encourage good health habits. Government must now take on this responsibility and help those who do not know the best way to help themselves.

I believe that health education for senior citizens is vital for them and for us. It is not a luxury. It is a necessity.

The resources to accomplish this goal already exist, and many more can be easily developed.

The schools of public health can design a lecture series or a schedule of issues to be presented to senior citizens. I see them also preparing videotapes on such topics as hypertension and heart problems, arthritis, visual problems, diabetes, exercise and so forth. These videotapes could be used by the "leader" of a group of older citizens in areas where lecturers were not available. In this way, doctors, physical therapists, psychologists and other top professionals could educate people whom they could not visit in person, and present programs on specific topics.

Another resource could be the many people in local health departments and in our DHR regional offices who are graduates of the School of Public Health. These people are health directors, health educators, public health nurses and sanitarians. They all could volunteer their time to lecture at senior centers and at service clubs to encourage those younger to practice good health habits.

There are other places where these same resources could be used to reach even more senior citizens. For instance, in Greensboro and High Point, we had public health nurses who made regular visits to apartment houses for the elderly. They answered questions about medication, encouraged proper diet and exercise, took blood pressures, and discussed individual concerns. Often they would pick up on other needs such as an older person having trouble eating because of a dental problem, or someone developing trouble hearing. They would contact to patient's doctor, and make sure that person got medical help.

Another good place to spread the gospel of health education is in church. There are Sunday school classes all over this State, made up of older people who do not go to senior citizens. These same resources could be made available to them if they were already in place for senior citizens.

I have given many talks to Sunday school classes, and to garden clubs and other groups made up of senior citizens. The most popular topic I have ever spoken on is "How To Stay Young After 39." Our maturing people really want to know how to stay young and be healthy, but they don't know where to go to learn. This bill would bring together a variety of resources to teach them the things they are so anxious to find out about.

I believe that coordination of these resources should be done on a local level, in each county. The schools of public health could design the courses and help with training instructors or teachers. They will work closely with local public health departments. The county public health department should serve as the lead agency, working with the medical society, colleges and other institutions to pull together the most effective program for that particular area. Local coordination would mean that special areas of interest could be addressed.

North Carolina has long been committed to improving the quality of life for our senior citizens. We want them to be able to spend their years as productive, independent citizens, involved in their community, active both mentally and physically, enjoying their independence, with financial security, enjoying a sense of individuality and a sense of belonging. This means keeping them out of institutions for as long as possible, and helping them to stay in their own homes. This means teaching them how to live a healthy life.

H.R. 4472 will bridge a gap that has too long existed, and fill a need that is vital to the well-being of both our elderly and our economy.

STATEMENT OF DR. SARAH T. MORROW, SECRETARY, NORTH CAROLINA DEPARTMENT OF HUMAN RESOURCES

Dr. MORROW. Thank you very much, Chairman Perkins, and I want to welcome you to North Carolina. We've heard of your services to our country for many years now. Mr. Raley, it's good to see you back, and Mr. Dean, you are welcome, too.

I'm happy to appear here today in support of H.R. 4472. I believe that the health education for older citizens has become essential in this changing society. Senior citizens today face the prospect of living longer than ever before. Those years can be happy, productive ones if one has good health; but, on the other hand, those extra years can be plagued with debilitating illness and rising medical bills.

Our good health depends on the way we live and the way we take care of ourselves. So many of our elderly people don't know how to stay healthy. They lack the knowledge, and that lack of knowledge costs them in terms of discomfort as well as in terms of dollars.

It costs every other American, too.

In 1982, while the Consumer Price Index for all items went up 3.9 percent, the cost of health care grew by 11 percent. We cannot

afford to have our third largest industry growing at more than twice the rate of the rest of the economy.

Medicaid costs are equally disturbing, and I have the responsibility of the medicaid in the State of North Carolina. Last year our medicaid payments rose 10 percent to over $539 million; 39.6 percent of those payments were for services to our elderly. The age group that this proposed legislation would help is the very group that takes the largest chunk of the medicaid budget.

Prevention of health problems is an important part of the solution to our costs—and a key to prevention is health education. It can make a difference not only in whether our elderly are healthy or ill, but it also affects the degree of the illness and lessens the severity of many problems.

Here again, we're talking about dollars—the difference between a condition that can be treated at home or one that requires institutional care.

In November 1983, medicaid in North Carolina paid $1,069 per person for nursing home care, and only $323 per person for in-home care. Now, although this figure for in-home care does not include the cost of upkeep of the home and other personal expenses, it's still a very significant savings. Clearly, both our elderly and our economy benefit from in-home care because physically and psychologically the elderly are better off in their own homes.

Now, there is another important reason why we must take responsibility for the teaching of our old people to maintain a healthy lifestyle. Often, there is no one else to do it because the tradition of families caring for their own elderly is fading fast. No longer can we assume that a younger relative is in the home watching out for the diet, the medication, and so forth.

The trend toward living away from one's family is growing, and it's growing faster in North Carolina than it is in the rest of the Nation. In 1970, just under 16 percent of our older people were living with relatives, but by 1980 that figure was just under 10 percent--a drop of nearly 6 percent. During the same years the national rate dropped by about 3½ percent.

We can no longer count on other family members in the home to encourage good health habits. Government and volunteers must now take on this responsibility and help those who do not know the best way to help themselves.

I believe that health education for senior citizens is vital for them and for us. It is no longer a luxury; it's a necessity. The resources to accomplish this goal in North Carolina I feel already exist, and many more can be easily developed. The schools of public health can design a lecture series or a schedule of issues to be presented to the senior citizens. I see the schools of public health, too, with the ability to develop videotapes on such topics as hypertension, heart trouble, arthritis, visual problems, diabetes, exercise, and so forth. The videotapes could be used by leaders of groups of senior citizens in areas where lectures could not be available. In this way the doctors, the physical therapists, psychologists, and other top professionals could educate the people whom they could not visit in person and present programs on specific topics and I would see these elaborated upon by a group leader.

In North Carolina another source could be the many people in our local health departments and in our Department of Human Resources regional offices who are graduates of the schools of public health. These people are health directors, health educators, public health nurses, and sanitarians. They could all volunteer their time to lecture at senior citizen centers and at service clubs to encourage even those younger to practice good health habits.

There are other places where these same resources could be used to reach even more senior citizens. For instance, in Greensboro and High Point, when I was the health director there we had public health nurses to regularly visit the highrise housing apartments for the elderly to take their blood pressure and do individual counseling with them, and often they would pick up other needs such as an older person that was having trouble eating due to the fact that he or she had tooth trouble, and they would make the necessary contacts either with a dentist or with a physician if necessary to make sure that the person got the necessary health care. Unfortunately, those services have been somewhat curtailed by the public health department, but I'm pleased that the schools of nursing in that area are picking up some of the same services in visiting these elderly in senior citizen centers as well as the highrise housing projects.

Now, another good place to spread the gospel of health education is in the church because there are Sunday School classes in which there are older people who make up that particular class, and many of these people do not go to our senior citizens, but they get to Sunday School on Sunday. The same people resources or instruction could be made available to them if they were already, as they have been doing, in the senior citizens centers.

Now, I've given a number of classes to Sunday School groups and the garden clubs and other groups of senior citizens, and the most popular talk that I've given is one that's entitled "How To Stay Young After 39," and I can tell you that everybody wants to know how to stay young and healthy, and this bill, as I see it, would bring together a variety of resources to teach people how to stay young after 39.

I think that we need a lot of coordination of resources that are already in existence in our communities. This can be done at the local level. Dean Bondurant brought out how important it is to do things at the local level because communities do differ, their resources differ.

I would see that the schools of public health could design the courses and help with the training of the instructors or the teachers, and they'd work closely with our public health department. I would see the county public health department, because we have one in each county, as being the lead agency in North Carolina. They, working closely with the area health education centers, with the Medical Society and other professional groups, colleges and institutions, could pull together, I think, a very effective program for that particular area.

Local coordination would mean that special areas of interest could be addressed. North Carolina has long been committed to improving the quality of life for our senior citizens. When Governor Hunt became Governor in 1977 one of his priorities was to develop

adequate programs for our older citizens. We want our older citizens to be able to spend their years as productive independent citizens involved in their communities, active both mentally and physically, enjoying their independence with financial security, and enjoying a sense of individuality and a sense of belonging, and this means keeping them out of institutions as long as is humanly possible, and helping them to stay in their own homes. That means they need to enjoy a healthy life.

H.R. 4472 will bridge a gap that I think has too long existed, and fill a need that is vital to the well-being of both our elderly and to our economy, and I would just say that knowing Dean Bondurant as I do, and Dean Ibrahim, that I would like to volunteer North Carolina as a pilot.

Mr. ANDREWS. Thank you. That's very gratifying, Dr. Morrow. We certainly do appreciate your efforts. Mr. Chairman.

Chairman PERKINS. The testimony was so clear and convincing I don't think it would serve any useful purpose for me to ask you any questions; however, I am interested to know your opinion regarding a requirement under Hilburton where funds were made available to build Hilburton facilities throughout the Nation. In the early seventies, however, we eliminated Hilburton funds completely. A hospital no longer has the responsibility as a matter of law to admit poor patients who may not have any medicaid. How do you feel about the situation as it would apply to the elderly if they needed to get into the hospital and do not have medicare or medicaid. There are a few, or several old people that never worked, or never paid into Social Security, up and down these hollows and creeks. I know it's hard to visualize, but I have a whole lot of those people in my district that didn't get involved in the mining, but just lived up in the heads of these hollows and didn't go out into public. They made a living, a very difficult living on those little farms. Now they do not have any medicaid or medicare cards, and several of them have gone to the hospitals and have not been accepted. What do you feel we should do in a situation like that for these senior citizens, when they are ill and need to go to a hospital? That's just another aspect that I want to discuss with you. From your background and experience I thought you would be in a good position to give Perkins some advice. I get letters along that line where people have been turned down.

Dr. MORROW. Yes; I know this happens, and it even happens in North Carolina, Congressman. Where we do have county hospitals counties have been absorbing the costs of care of a number of these people who don't have other benefits, and they are not only senior citizens, but they are others also who just don't have the wherewithal to make the payments. Now, when you don't have a county hospital where county government is going to absorb costs, of course, you can refer them to North Carolina Memorial Hospital, and that's where the State absorbs some costs.

When you have only private for profit hospitals operating and receiving more and more patients, and we're seeing more and more of those coming into being in North Carolina, I think there that we're not going to see as much generosity unless some payment mechanism can be established for these persons, and I would suggest that we have not just the senior citizens, but the others that

we'll have to consider if any payment mechanism is established. I don't have the solution for you.

Chairman PERKINS. Would it seem fair if you assessed the responsibility on all of those private hospitals for that purpose and make them assume so much of the burden by law, or would it put too much of a burden on those private hospitals if we required that all of them assume some of that responsibility?

Dr. MORROW. As long as the responsibility were evenly distributed, that's one thing. But right now hospitals are coming under a great deal of stress. In North Carolina we have 153 general hospitals. 105 of those are, as of October first, were influenced by the DRG's under medicare, the Diagnosis Related Groups, and we are reading as recently as last Saturday where a number of hospitals are experiencing reduced occupancy rates, and have closed off over 1000 beds in North Carolina. So I would say that to place upon them additional burdens, financial burdens, at this time would not be an opportune time to do it.

Chairman PERKINS. Thank you very much.

Mr. ANDREWS. Mr. Dean.

Mr. DEAN. I just have one simple question. On page 7 of your testimony you state that the county public health departments should serve as the lead agency.

Dr. MORROW. Yes.

Mr. DEAN. Are you suggesting then that the grant go to the county public health agency, or are you in agreement with the legislation that it should go to the institution of higher education?

Dr. MORROW. I think it could be to the institution of higher education, and I think, knowing how closely that institution works with the local public health departments I don't see that this would be any problem.

Mr. DEAN. Thank you very much.

Mr. ANDREWS. I might just add that as you spoke I was thinking that we have talked a lot about the utilization of the some 3,300 senior citizens centers, and I do perceive that that is more than a nucleus of what would be utilized as the so-called classroom. However, I certainly agree with you. I'm not intending to suggest that because they would be the source of the classrooms, that they necessarily would be the only classrooms. As you say in your statement, there are surely many others, some of which you have alluded to, and I'm sure there are yet others that neither of us have envisioned. However, I do think there is a danger, Sarah that we can proliferate this idea too far and hence, perhaps, reach the point where too many cooks spoil the broth. I do believe we're going to have to try to keep the idea essentially as one of molding together the resources to which I have alluded. Others would serve as supplements or adjuncts and be welcomed as such; but I think we could lose if we get too many levels involved. I'm afraid we'd just get a hodgepodge.

We're not trying here, for instance, to treat illnesses. That isn't to say that if somebody goes to a class prior to the day or evening of instruction and determine its makeup and ascertains that somebody has serious heart trouble that they shouldn't refer them on to a hospital. Of course they should. I'm sure they would; but it would be to refer them there, and certainly not to attempt to treat them.

That in itself is a huge challenge already within the purview of law, both State, Federal, and local. It is, as well, a private initiative. Hopefully, it can be improved upon, but that's not really the essence of what we are attempting to do here, and I hope we don't get too far afield.

Thank you very much, and we'll look forward to working with you in the months ahead. Dr. Morrow. Thank you.

Mr. ANDREWS. Mr. Ernest Messer. I don't need to tell you about him. We've served in the legislature in decades past. Ernest, we're most pleased to have you with us here this morning, and look forward very much to your counsel, experience, and assistance here.

Mr. Messer is assistant secretary for the Division of Aging in the North Carolina Department of Human Resources. He is well known among the elderly as their true friend, sort of North Carolina's version of Claude Pepper, I suppose. Ernest, we're most pleased to have you here.

[Prepared statement of Ernest B. Messer follows:]

PREPARED STATEMENT OF ERNEST B. MESSER, ASSISTANT SECRETARY, NORTH CAROLINA DEPARTMENT OF HUMAN RESOURCES, DIVISION OF AGING

Mr. Chairman, Members of the Subcommittee on Human Resources of the Committee on Education and Labor, Ladies and Gentlemen:

The population is aging. People are living longer.

In 1935, the year the Social Security Act was passed, the average life expectancy at birth was 61 years; the life expectancy in 1983 is 74.5 years.

As a result of this increased life expectancy, the age 65 plus population is increasing faster than any other age group.

In the United States, 25,500,000 persons are aged 65 or older. They constitute 11.3 percent of the population. According to estimates, by the year 2000 this number will have increased to 36,000,000 and will make up approximately 16 percent of the population.

In North Carolina, 675,000 persons are 65 years of age or older. By the year 2000 this number will exceed one million.

Nationwide (North Carolina statistics are comparable), five percent of the elderly are confined to institutions. An additional 15 percent need assistance to remain independent or semi-independent.

Annual health care expenditures in the United States are now (1983) in excess of $320 billion and are increasing at an annual rate of more than 15 percent. And senior citizens, although they consitute only 11.3 percent of the population, consume 31 percent of the health care.

Unless we reduce the percentage of elderly in institutions and the percentage needing help to remain in their own homes, these constant percentages applied against increasing numbers of elderly will increase health needs beyond our ability to provide them.

And the increasing costs of these health care services will be beyond our ability to pay.

Doctors tell us that many of the elderly are institutionalized or are ill because of their life style, because, through ignorance or neglect, they failed to follow elementary principles of health care.

We in the North Carolina Division of Aging recognize that a major thrust of our efforts must be directed towards educating the elderly in principles and practices of health maintenance leading them to do what they can to prevent or postpone physical decline and deterioration.

We are trying to educate senior adults to the end that they:

1. Avoid the overuse and misuse of medicines and alcohol;
2. Avoid the overuse and misuse of medical facilities and the overdependence on medical personnel;
3. Observe minimum standards of physical fitness;
4. Adjust the consumptions of food to fit their needs; and
5. Learn to cope with stress.

Our resources are woefully inadequate to properly cope with these problems. We need help.

The passage of H.R. 4472 will provide an important impetus to our efforts to promote health maintenance by the elderly:

1. By establishing a Title VII—Health Education—section to the Older Americans Act, a mandate will be given to all state organizations on aging to place major emphasis on health maintenance;

2. It will direct educational institutions of all types and levels to devote some of their teaching expertise toward properly educating the elderly in the necessary principles and practices of health care;

3. It will provide for more and better use of some of our facilities, such as senior centers;

4. It will give senior citizens the tools to prevent or cope with or better understand many of their health problems;

5. The program will be cost effective, in that it will slow down the drift toward dependency and institutionalization. It can stem the increasing costs of Medicare and Medicaid;

6. This program can improve the life-style of the elderly, enable them to be independent and live at home longer, enable them to enter more actively into determining what their own future shall be like.

We do recommend, however, that H.R. 4472 be expanded to the extent that state departments or divisions of aging (or the aging network in each state, by whatever designation) be given an active role in designing and implementing this health education plan.

To proceed without active involvement by state agencies on aging will involve a duplication of effort that is not necessary. Education institutions have the instructors, but the aging network has the people to be instructed. The two should work together on this health education plan.

We in the North Carolina Division of Aging respectfully request that the Congress enact H.R. 4472.

STATEMENT OF ERNEST B. MESSER, ASSISTANT SECRETARY, DIVISION OF AGING, NORTH CAROLINA DEPARTMENT OF HUMAN RESOURCES

Mr. MESSER. Thank you, Congressman Andrews, Congressman Perkins and members of the staff. I am delighted to be here. Congressman Andrews, as you mentioned, we served in the General Assembly a number of years, and of course you went on and did a lot better than I did.

Mr. ANDREWS. No, I wouldn't agree with that. Let's not get into an argument.

Mr. MESSER. But I am delighted to have this opportunity to comment on H.R. 4472. The population is aging, people are living longer. In 1935, the year the Social Security Act was passed, the average life expectancy was 61 years. The average life expectancy in 1983 is 74.5 years. As a result of this increased life expectancy the age 65-plus population is increasing faster than any other age group. In the United States 25.5 million persons are aged 65 or older. They constitute 11.3 percent of the population.

According to estimates, by the year 2000 this number will have increased to 36 million, and will make up approximately 16 percent of the population.

In North Carolina 675,000 persons are aged 65 years or older, and by the year 2000 this number will exceed 1 million. Nationwide, and North Carolina statistics are comparable, 5 percent of the elderly are confined to institutions. An additional 15 percent need assistance to remain independent or semi-independent.

Annual health care expenditures in the United States are now in excess of $320 million, and are increasing at an annual rate of more than 15 percent, and senior citizens, although they constitute

only 11.3 percent of the population, consume 31 percent of the health care in the United States.

Unless we reduce the percentage of elderly in institutions and the percentage needing help to remain in their own homes these constant percentages applied against increasing numbers of elderly will increase health care needs beyond our ability to provide them, and the increasing costs of health care services will be beyond our ability to pay.

Doctors tell us that many of the elderly are institutionalized or are ill because of their life style; because of their ignorance or neglect they fail to follow elementary principles of health care. We in the North Carolina Division of Aging recognize that a major thrust of our efforts must be directed toward educating the elderly in principles and practice of health maintenance, leading them to do what they can to prevent or postpone physical decline and deterioration.

And as an addition to what I've written I've filed with the committee a document that was developed in North Carolina entitled A Health Promotion Program for Older Adults, which we have tried to carry statewide, and have to date, trained about 1,800 trainers to try to help us reach the 950,000 persons in North Carolina who are 60 years of age and over. And that, I think, is a big problem that we have, is to reach the entire population and not just a small bit of it.

[Information referred to follows:]

North Carolina
Department of Human Resources
Division of Aging

LIFE

A HEALTH PROMOTION PROGRAM FOR OLDER ADULTS

BY:
NORTH CAROLINA DIVISION OF AGING
SUITE 200
708 HILLSBOROUGH STREET
RALEIGH, NORTH CAROLINA 27603
(919) 733-3983

LIFE LIVING INDEPENDENTLY FOR ELDERS

North Carolina Department of Human Resources

Division of Aging
Ernest B. Messer, Assistant Secretary

James B. Hunt Jr.
Governor
Sarah T. Morrow, M.D., M.P.H.
Secretary
Tom Gilmore
Deputy Secretary

FORWARD

THE NORTH CAROLINA DIVISION OF AGING STRONGLY BELIEVES IN HEALTH PROMOTION AND DISEASE PREVENTION FOR OUR OLDER POPULATION. THE MAJOR PURPOSES OF THE LIFE PROGRAM IS TO ENHANCE THE QUALITY OF LIFE FOR OLDER ADULTS BY PREVENTING MANY HEALTH PROBLEMS BEFORE THEY OCCUR. THE POPULATION BOOM AMONG OLDER CITIZENS, COUPLED WITH LIMITED RESOURCES, MEANS THAT THE OLDER INDIVIDUALS MUST ASSUME A GREATER RESPONSIBILITY IN MAINTAINING THEIR OWN HEALTH. THE LIFE PROGRAM EMPHASIZES AN ACTIVE LIFESTYLE CONSISTING OF HEALTH AND RECREATION, STRESS MANAGEMENT, GOOD NUTRITION AND COMMUNITY INVOLVEMENT.

IT IS HOPED THAT THE INFORMATION IN THIS MANUAL AND THE LIFE WORKSHOP EXPERIENCE WILL ENABLE LOCAL COMMUNITIES TO CONTINUE TO EDUCATE AND MOTIVATE OLDER PEOPLE TO LEAD A LONG AND HEALTHY LIFE.

Ernest B. Messer
ERNEST B. MESSER
ASSISTANT SECRETARY

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WHAT IS LIFE?

LIFE, WHICH STANDS FOR LIVING INDEPENDENTLY FOR ELDERS IS CONSIDERED TO BE A SELF-CARE EDUCATIONAL PROGRAM FOR OLDER ADULTS WITH AN INITIAL EMPHASIS ON HEALTH PROMOTION. THIS EDUCATIONAL PROGRAM FOCUSES ON THE INDIVIDUAL'S LIFE STYLE, WHILE CONCENTRATING ON WHAT THE PERSON CAN DO FOR HIM/HERSELF TO CREATE A BETTER LIFE STYLE. WITH THE EMPHASIS ON PREVENTIVE EDUCATION, THE LIFE PROGRAM TEACHES SENIOR CITIZENS TO HELP THEMSELVES TO ACHIEVE BETTER PHYSICAL AND MENTAL HEALTH, ALONG WITH INFORMING THEM ON HOW TO MAKE BETTER USE OF THE HEALTH AND SOCIAL SERVICE SYSTEMS IN THEIR COMMUNITIES. THIS MEANS KNOWING WHAT SERVICES ARE AVAILABLE IN THE COMMUNITY, AND HAVING THE ABILITY TO USE SUCH AGENCIES.

OLDER ADULTS, LIKE ANY OTHER AGE GROUP, HAVE A STRONG DESIRE TO MAINTAIN THEIR HEALTH, SOCIAL WELL-BEING, AND CAPACITY FOR INDEPENDENT LIVING. THE LIFE PROGRAM ADDRESSES THESE CONCERNS. WITH LIMITED RESOURCES FOR SUPPORTIVE SERVICES AND PROGRAMS FOR OLDER ADULTS, ALONG WITH THE EVER-INCREASING NUMBER OF OLDER PEOPLE WHO NEED SOME TYPE OF SUPPORT, IT IS EXTREMELY IMPORTANT THAT OLDER ADULTS START HELPING THEMSELVES SO THAT THEY DO NOT BECOME DEPENDENT ON A FORMAL SUPPORT SYSTEM WHICH MAY OR MAY NOT BE THERE WHEN THEY NEED IT. THIS IS ESSENTIALLY THE REASON WHY THE LIFE PROGRAM WAS DEVELOPED.

GOALS OF THE LIFE PROGRAM:

1. TO INFORM AND EDUCATE OLDER ADULTS ON HOW TO MAINTAIN AND ENHANCE THEIR SELF-SUFFICIENCY, THEIR HEALTH, AND THEIR INVOLVEMENT IN SOCIETY.
2. TO STIMULATE HEALTHIER ATTITUDES AND BEHAVORS LEADING TO POSITIVE ACTION ON THE PART OF THE INDIVIDUAL, WHICH COULD INCLUDE MAKING SIGNIFICANT LIFE STYLE CHANGES IN ORDER TO IMPROVE ONE'S HEALTH AND HAPPINESS.

TOPICS/PRESENTERS/MAJOR POINTS OF LIFE

INTRODUCTION/CONCLUSION/LIFE COORDINATOR - Steve Freedman, Chief of Plans and Policy Section, North Carolina Division of Aging

1) STRESS MANAGEMENT - George Misoyianis, Stress Management Program Manager, North Carolina Division of Health Services

Major Points:

- Stress can be positive or negative
- You can control the amount of stress/distress in your life
- The four areas of stress management are nutrition, physical exercise, relaxation, and humor
- Emotions can maintain "positive stress"
- People need people.

2) HEALTH, FITNESS AND RECREATION - Margot Raynor, Health and Recreation Specialist, North Carolina Division of Aging

Major Points:

- "Use it, or lose it!"
- Inactivity is much more dangerous than sensible activity
- Productive and satisfying use of leisure time is vital to our holistic well being
- Choice of recreational endeavors is individual so it can meet the appropriate needs of each person.

3) NUTRITION - Georgia Kannon, Nutritionist, North Carolina Division of Aging

Major Points:

- You are what you eat
- Food variety is essential to good health
- Kick the salt habit
- Eat well to live well
- Fat or thin: The choice is yours!

4) INVOLVEMENT AND INTERGENERATIONAL ACTIVITIES - Jim Whaley, Program Development Specialist, and Jackie Clark, Intergenerational Program Specialist, North Carolina Division of Aging

Major Points:

- Active and involved people are happier and healthier
- Retirement and leisure time are times of opportunity
- Reach out! The community needs its seniors
- Bridge the generation gap with JOY.

IMPLEMENTATION STRATEGY:

THE NORTH CAROLINA DIVISION OF AGING DEVELOPED THE FOUR TRAINING MODULES (FITNESS/RECREATION, NUTRITION, STRESS MANAGEMENT, AND INVOLVEMENT) AND CONDUCTED ONE-DAY TRAINING SESSIONS THROUGHOUT THE STATE. THE PARTICIPANTS IN THE TRAINING WERE 100 OLDER ADULTS SELECTIVELY INVITED FOR EACH SESSION. OVER 2,000 OLDER ADULTS WERE TRAINED ACROSS THE STATE AS PART OF THE 18 REGIONAL TRAINING SESSIONS. THESE PARTICIPANTS ARE EXPECTED TO CREATE A DEMAND FOR ADDITIONAL TRAINING IN THEIR COMMUNITIES, AND TO RECRUIT OTHER OLDER ADULTS FOR LOCAL PROGRAMS. THE INTENTION IS FOR THE LIFE PROGRAM TO BE ONGOING, AND TO MEET THE SPECIFIC NEEDS AND INTERESTS OF THE OLDER PEOPLE IN MANY LOCALITIES THROUGHOUT NORTH CAROLINA. REGIONAL ADVISORY COMMITTEES WERE SET UP AND SUPPORTED BY THE AREA AGENCIES ON AGING FOR THE PURPOSE OF DEVELOPING AND IMPLEMENTING FOLLOW-UP EDUCATIONAL PROGRAMS IN THE FOUR SUBJECT AREAS. THESE COMMITTEES CONSIST OF MANY INDIVIDUALS WHO REPRESENT LOCAL TRAINING RESOURCES. FOR SPECIFIC INFORMATION ON HOW THE PROGRAM WAS IMPLEMENTED, REFER TO THE LOGISTICS PACKAGE IN THE APPENDIX.

THE LIFE PROGRAM CAN BE ADAPTED TO MANY DIFFERENT GROUPS OF PEOPLE AND PRESENTED IN A VARIETY OF SETTINGS. IT CAN WORK VERY EFFECTIVELY IN CHURCH GROUPS, PRIVATE CLUBS, SENIOR CENTERS, NUTRITION SITES, ELDERLY HOUSING SITES AND LONG-TERM CARE INSTITUTIONS.

THE LIFE PROGRAM

1. MAJOR DESIGN CONSIDERATIONS OF PROGRAM:

   - Participatory learning/audience involvement
   - Humor and fun incorporated into training techniques
   - Involve community agencies in a "resource room"
   - Use of a variety of training styles and audio-visual techniques throughout the day
   - Provide motivation/appetizers for participants to desire more in-depth training
   - Time for socialization among participants/healthy snack breaks
   - Plan with, not for, older adults
   - Allow adaptability and flexibility in use of resources and future training plans - Provide basic componenets of a quality program.

2. * BASIC TRAINING PHILOSOPHY OF LIFE:

   One must change attitudes to change behaviors!

3. RESULTS OF LIFE PARTICIPANT SURVEY (36% RESPONSE RATE):

   - 88% of the participants improved their own lifestyle because of the LIFE Workshop.
   - 89% helped their friends and family members improve their lifestyles.
   - 54% made presentations to a group of people (church, civic club, etc.) on the ideas of good health and wellness presented in LIFE.
   - 96% would like to have more programs life LIFE in their community.

APPENDIX B

State of North Carolina

JAMES B. HUNT, JR.
GOVERNOR

WHEREAS, North Carolina now has the nation's thirteenth largest elderly population with more than 850,000 citizens sixty years of age or older, and by 1990 it is estimated there will be over one million senior North Carolinians; and

WHEREAS, advances in modern technology and medical science have helped people live longer and fuller lives; and

WHEREAS, good health in later life leads to more independence, mobility, community involvement, and happiness, as well as preventing unnecessary institutional care; and

WHEREAS, many of the health problems suffered by older adults are caused by inactive, unhealthy lifestyles; and

WHEREAS, health care experts recommend an active lifestyle consisting of exercising, recreation, good nutrition, stress management, and community involvement to prolong life and reduce negative conditions usually associated with aging; and

WHEREAS, the LIFE (Living Independently for Elders) Program is designed to improve the health and well-being of older adults in North Carolina; now

THEREFORE, I, James B. Hunt, Jr., Governor of the State of North Carolina, do hereby proclaim 1983 as the year of LIFE.

By the Governor:

James B. Hunt, Jr.

SAMPLE LIFE NEWS ARTICLE

Team Carrying Healthy Message

By SCOTTEE CANTRELL
Sentinel Staff Reporter

You get upset when your friend ignores you entering church.

So, you:

- Go up after the church service and ask him why.
- Vow to ignore him when you leave church. Then go home and call up 25 friends telling them how much it didn't bother you.

The correct way to deal with the situation is through action: talk to your friend, resolve the conflict and relax. That is one prescription for relieving stress — a prime cause of disease and death — according to George Misoyianis, a stress-management program manager.

Misoyianis and a team from the North Carolina Department of Human Resources, under the supervision of the Division of Aging, put the emphasis on action at a workshop here yesterday, telling older adults how to stay active and keep healthy.

The team is taking the program called LIFE (Living Independently for Elders) across North Carolina to help older adults learn to help themselves and to encourage them to avoid unnecessary institutionalization, said Steve Freedman of the Division of Aging.

Winston-Salem was the team's fifth stop. The all-day workshop attracted more than 75 senior citizens and members of groups and clubs working with older adults from the five counties in the Northwest Piedmont Council of Governments.

The program got its start when the division realized that the elderly population was growing and needed more services, while the funding for such supportive services was decreasing, Freedman said.

To combat the problems, an education program was developed to help the elderly learn to do for themselves, beginning with health, he said.

The workshop, held at First Christian Church, dealt with stress management; nutrition; health, fitness and recreation; and involvement in intergeneration activities.

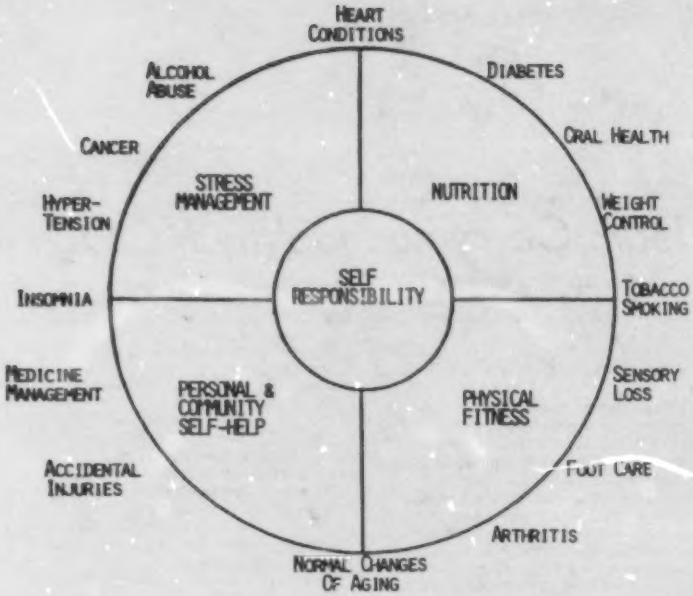
Freedman said the division plans to follow this workshop with a series on lifestyle alternatives — housing options, financial and retirement planning, disease prevention and advocacy — by February.

But the programs are not supposed to be just one-day affairs, Freedman said. The division has required the state's 18 regional COGs, through their agencies on aging, to keep the process going.

The Northwest COG has formed a LIFE committee to pick up where the division leaves off. The committee will plan how the program can be implemented in the community, said Rodessa Mitchell, aging program administrator for the COG.

The committee hopes to work with senior citizens who participated in yesterday's workshop and develop activities with them for their groups, Ms. Mitchell said.

The initial response to LIFE has been positive, Freedman said, adding that there will be continuing evaluation to determine if it is effective.



THE PILLARS OF HEALTH PROMOTION AND SOME COMMON HEALTH CONCERNS OF OLDER ADULTS.

Living Independently For Elders

"A Health Promotion Program For Older Adults"

LIFE — A health promotion program for older adults, introduces information and self-help techniques for developing an active, healthy lifestyle.

The program is designed to help older adults make intelligent choices about their lifestyles that will keep them healthy.

The **LIFE** program focuses on fitness and recreation, proper nutrition, coping with stress and remaining active in the community.

The **LIFE** program is being implemented in North Carolina through educational materials and regional training workshops.

The focus of **LIFE** is to train older adults to develop and expand the program in their communities in places such as senior/community centers, religious organizations, rest homes, nursing homes, clubs and civic organiions.

PROGRAM STRUCTURE

A healthy lifestyle includes four major components and their interaction:

fitness/recreation

stress management

nutrition

community involvement

The **LIFE** program consists of presentations, training sessions and educational materials on each topic area. The goal of **LIFE** is to provide older adults with the tools to build an active, healthy and happy life.

DELIVERY STRUCTURE

The North Carolina aging network is divided into 18 planning and service areas. In each of these areas, 100 older adults have been selected to attend the regional training session. These individuals, working with area agencies on aging and regional advisory committees, will develop ongoing education programs in their communities.

For more information on the **LIFE** Program, write or call:

North Carolina
Department of Human Resources
Division of Aging
708 Hillsborough Street
Raleigh, NC 27603

(919) 733-3983

NC Department of Human Resources
Division of Aging
708 Hillsborough Street
Raleigh, NC 27603

Fellow North Carolinians:

North Carolinians are living longer.

In an effort to help you maintain your health, retain your dignity and live a full and happy life, the Division of Aging, in cooperation with the Area Agencies on Aging, has developed a health promotion and wellness program for older adults called LIFE, Living Independently for Elders.

LIFE focuses on fitness and recreation, proper nutrition, learning to cope with stress and the importance of remaining active in the community.

A presentation of the LIFE Program is scheduled for your area. We invite you to participate with other individuals in attending and implementing LIFE.

James B. Hunt, Jr.
Governor
State of North Carolina

Ernest B. Messer
Ernest B. Messer
Assistant Secretary
Department of Human Resources
Division of Aging

You are cordially invited to join
the North Carolina Department of Human Resources,
Division of Aging,
the Area Agency on Aging, and
other community leaders to introduce
"LIFE"
a health promotion and wellness program
for older adults.

Mr. MESSER. We are trying to educate senior adults to the end that they may first avoid the over-use and mis-use of medicines and alcohol, to avoid the overuse and misuse of medical facilities and overdependence on medical personnel, to observe minimal standards of physical fitness, adjust the consumptions of food to fit their needs, and learn to cope with stress.

Our resources are woefully inadequate to properly cope with these problems. We need and I say we reach all the people we can, but we cannot do the job like it needs to be done. We need help. The passage of H.R. 4472 will provide an important impetus to our efforts to promote health maintenance by the elderly, first by establishing a title VII health education section to the Older Americans Act. A mandate will be given to all State organizations on aging to place major emphasis on health maintenance. Second, it will direct educational institutions of all types and levels to devote some of their teaching expertise toward properly educating the elderly in the necessary principles and practices of health care. Third, it will provide for more and better use of some of our facilities such as senior centers. Fourth, it will give senior citizens the tools to prevent or cope with, or better understand many of their health problems. Fifth, the program will be cost effective in that it will slowdown the drift toward dependence and institutionalization. It can stem the increasing costs of medicare and medicaid.

And in connection with some of the remarks that I've made, I hope the Congress, in passing this, will not fragment the program to the extent that we're trying to take money and scatter it all over the countryside so that nobody knows what we have. It needs to be coordinated and pooled together.

This program can improve the lifestyle of the elderly and enable them to be independent and live at home longer, enable them to

enter more actively into determining what their own future shall be like.

We do recommend, however, that H.R. 4472 be expanded to the extent that State departments or divisions of aging, or the aging network in each State, by whatever designation, be given an active role in helping to design and implement this education plan. To proceed without active involvement by State agencies on aging will involve a duplication of effort that is not necessary. Educational institutions have the instructors, but the aging network has the people to be instructed. The two should work together on this health education plan.

And I want to emphasize that just a little more; that an education plan that is developed apart from the older people and delivered to them, and they are told that this has been delivered to them, that plan will not be as effective and will not be as cost effective, in my opinion, as one that is developed with the active cooperation and involvement of our older people.

We in the North Carolina Division of Aging respectfully request that the Congress enact H.R. 4472, and I thank the committee for the opportunity to be here today.

Mr. ANDREWS. Thank you again, my good friend. May I say that you and Dr. Morrow both made reference to some of the potentials of the program. Certainly, I hope, by whatever means we can, as we induce our elderly citizens to become involved with this should it become a law, we bring to those classrooms or settings, not only the elderly, but anyone who presently or prospectively is going to be working with the elderly—as custodian, or assistant or director—family members or person hired to stay with them; we would like those persons to participate as well as the elderly themselves.

As to the methods, Ernest, of reaching the total number, someone has pointed out that, in a statement I made, I referred to the fact that some 9 million senior citizens attended these senior citizens centers last year, but the total number of elderly I understand to be something like 25 million. So they have, I believe, misunderstood that I'm trying to reach only that 9 of the 25 million. We obviously would be trying to reach all the senior citizens, or certainly as many of them as we can by any legitimate means available. There are representatives here today, for instance, from the American Association of Retired Persons, which I think has some 15 million members. They have certain mail-out's and contacts with their members, who are more than half of that 25 million. They can be of immense assistance. Certainly, they can assist in notifying and hopefully inducing people to come to the senior citizen centers, or wherever they may be taught, who otherwise don't come. There is a Federation of Retired Government Employees, as just another example, who have millions of members similarly. Certainly, you have frequent and intimate contact with many of that number who are North Carolinians, and likewise I know that you have a counterpart in all of the States who, likewise, already render a most valuable service and certainly could be of help. Just what degree and how I don't now quite know, structurally, but surely we would want you to be involved from now on in helping us determine just what direction this should go, and then in helping implement whatever program may evolve from these efforts. Thank you again,

and we'll look forward to working with you in every possible way. Mr. Chairman

Chairman PERKINS. Well, let me compliment Mr. Messer for his testimony. It was very clear and convincing, and I don't know how far we can go in covering the whole waterfront, but we will go as far as we can, and make the program as effective as we possibly can. Thank you very much, Mr. Messer. Mr. Dean, do you have a question?

Mr. DEAN. Yes, I just have a couple of questions. You seem to be emphasizing the necessity of having the State division of aging involved in the planning. Let us say the University of North Carolina at Chapel Hill got a grant to provide health education in the Chapel Hill area. Would you give some examples of what would be wrong with that? Why can't the university here just work with the aging community in the Chapel Hill area? Why is State participation necessary in your view?

Mr. MESSER. The State agency, in the first place, has contact with the aging network throughout North Carolina. We would know some of the areas where there are concentrations of older people and where the most need probably would be in some cases. You see, in addition to this we have custody of the process in North Carolina which deals with the monitoring of health care of older people, and I think it would be important that the university, or whoever developed an educational program that was proper, would work with us to find out the areas where it would be best placed.

You see, we also have custody of the senior centers in North Carolina. We can help provide the facilities, plan the facilities, enroll the people, designate the ones who ought to be in it if you want it to be that way, and try to reach that unreached group, who ultimately will appear and want entrance into the health care system somewhere along the way.

We have the feedback from these people on what they need, what they don't know and what they ought to learn. I think the agencies on aging could add quite a bit to the planning process—not to run the program, because I think when you fragment it that way it deteriorates from the program, but as a part of the planning and the implementation the aging network ought to be involved in any State that this is set up in.

Mr. DEAN. Would you feel that before the University of North Carolina at Chapel Hill, or any other university, submitted an application for a grant, that it should be approved by your office before it is sent to HHS.

Mr. MESSER. No, no; but I think before the University says that they're going to go over to Durham to put in a program, or before they decide even what the contents of the program should be, that we should be a part of it, and I know there will be other groups that will be involved in planning what the contents of these programs will be.

For example, we're interested in physical education, physical activity among the older people, and doctors are very specific in that being a process that is necessary for slowing down a number of diseases that beset our older people, such as for example, osteoperosis.

We ought to be sure that the programs that are developed will meet the needs of our people where they are presented. We will be

interested in people who live in areas that have no senior centers, and that question has come up about how you are going to get it there. Well, someone suggested that the health department handle it. It may be that the health department may not be capable, but I think the teaching institutions can set up an outreach program, an extension program where with trained personnel they can go to any part of North Carolina and teach courses without moving the whole university there, or without setting up a physical structure especially for that. I think through extension, training people to go out into North Carolina and present this program, it can be done all over North Carolina if we can get that many people involved.

Mr. DEAN. Let me ask one other question. In your preparation for testimony today have you given any thought to what it would cost to set up a program on a statewide basis in North Carolina?

Mr. Messer. No; I have not because I didn't have the basic information about the program, and I don't know how much it would cost our teaching institutions to provide the program. I think it would depend on how you would present it and how technical you would want the training to be.

Now, we in the Division of Aging have taken the position that we can do general teaching, or we can get people to do that in principles of health maintenance that do not involve medical technical processes, and can do it through the use of personnel who are not trained in the medical field, although some of these people do participate in it, and we have felt all along that you don't need to teach everybody to be a doctor or a nurse or anything like that to take care of their own health. But the basic principles of health maintenance, to most people, are not that complicated, in my opinion, and can be generally taught through North Carolina by a number of institutions.

Mr. DEAN. Thank you very much.

Chairman PERKINS. Let me compliment you. You made a good witness.

Mr. MESSER. Thank you.

Chairman PERKINS. The next witness is Dr. Marian K. Solleder. from the Association of the Advancement of Health Education, Greensboro, NC. And then we have L.J. Andolsek, president of the Federal Retired Employees Association. Is he here today? And do we have Mr. John T. Denning here today? Come around, Mr. Denning, and we'll listen to both of you before we question you.

[Prepared statement of Dr. Marian K. Solleder follows:]

PREPARED STATEMENT OF DR. MARIAN K. SOLLEDER, ASSOCIATION FOR THE ADVANCEMENT OF HEALTH EDUCATION

Chairman Perkins, Chairman Andrews, Distinguished Members of the Human Resources Subcommittee.

My name is Marian Solleder. I am a Professor of Health Education, and Assistant Dean of the School of Health, Physical Education, Recreation and Dance at the University of North Carolina at Greensboro. I have been a health educator for 25 years, and currently serve on the national Board of Directors and Executive Committee of the Association for the Advancement of Health Education. I am speaking today as a representative of the Association—an individual membership organization composed of health educators charged with the preservation and improvement of health through education. As a part of the 35,000 members of the American Alliance for Health, Physical Education, Recreation and Dance, the Association speaks for concerned educators in the area of health education.

Thank you for the opportunity to speak to you today about this very important issue of health educaton for elderly Americans.

First, I would like to commend Congressman Ike Andrews for introducing H.R. 4472, the Older Americans Personal Welfare Education and Training Act. Introduction of this bill demonstrates once again his commitment to elderly Americans and to creative solutions to human problems in an era of fiscal responsibility.

As a health educator, I am convinced of the need for health education for people of all ages. Change is the nature of life, and our minds, our bodies, and our health needs change as we move through life's stages. Education is, and should be a lifetime venture, not terminating with formal schooling in our youth. Lifetime learning about ourselves—health education—is particularly vital to us as we age, for it is during this time that the body undergoes rapid changes which can confuse and tax emotional, physical, and financial resources—at a time when such resources are limited.

As the bill points out, while the elderly make up only 11% of the population, they consume 29% of the total health care expenditures, and 50.5% of the Federal civilian health care expenditures. The elderly consume more over-the-counter and prescription drugs than any other segment of the American population. We know that the current figure of 25 million elderly Americans is growing and will drastically increase in the future. Health and health care will continue to be major concerns.

The need for health education is obvious. Senior Americans need to be educated about preventive measures they can take which could increase their life expectancy, and/or increase the quality of their lives. They need to be participants in their own health care, not just passive recipients of medical treatment. They need to have the chance to learn about themselves and about opportunities for wellness. They need to be allowed to take personal responsibility for their own health and welfare. This is what health education is all about.

Although the Association for the Advancement of Health Education is supportive of H.R. 4472, we question the exclusion of many health educators from the provision of health education as outlined in this bill. By restricting the delivery of health education services to Schools of Public Health, the vast expertise and resources of many of the nation's health educators are left untapped. We think this should not be allowed.

There are currently 23 Schools of Public Health across the United States. Only 14 of these offer public health education degrees. That means that as the bill is now written, only 14 schools nationwide would be available to serve the needs of 3,300 senior centers and the 9 million seniors in their programs.

The resources of health educators are much more vast. Three hundred and two colleges and universities across the country offer health education degrees. Of these, approximately 175 offer specific degrees in community health education. This includes 127 bachelors level programs, 83 masters level programs, 7 specialist degree programs and 33 doctoral degree level programs. These schools are distributed across the country, and are much more accessible than the 14 Schools of Public Health which have public health education programs. By including these additional health educators and health education programs in this bill, the potential services available to the elderly could be increased seven fold. In such fiscal times as these we believe it is wise to make use of all available resources. We do not believe that it was Chairman Andrews' intention to exclude these health educators and health education programs from this bill.

The Association for the Advancement of Health Education urges the subcommittee to amend 4472 to include colleges and universities with graduate programs of health education.

Again, I would like to thank Congressman Andrews for introducing this much needed bill, and I commend the subcommittee for holding hearings here in North Carolina.

Thank you.

Association for the
Advancement of Health
Education

AAHE
AAHE
AAHE

Association for the
Advancement of Health Education
1900 Association Drive
Reston, Virginia 22091
(703) 476-3440

The Leader in Health Education...

AAHE is a national association of professionals who have responsibility for improving America's health.

More than 6,500 health educators in

- public and private schools
- colleges and universities
- community health agencies
- business and industry
- clinical settings
- voluntary health agencies

join together to improve the quality of life in America.

Meeting the Challenge...

AAHE seeks the preservation and improvement of health through education. Members of AAHE share these basic goals:

- to develop dynamic programs of health education for all levels of the public
- to provide information, resources and services to professionals and the public
- to exert leadership in the improvement of health through school and community education programs
- to represent the interests of health educators regarding legislative issues
- to provide leadership in setting program standards and establishing effective health education
- to facilitate communication on health education issues between professionals and the public
- to maintain a liaison with organizations having related interests.

Providing Important Professional Benefits For You...

Health Education

Six times each year, this highly respected journal brings you outstanding articles and reliable regular features like book reviews and research abstracts. You'll stay well-informed on the critical issues in health education.

HE-XTRA

Three times each year, this informative AAHE newsletter brings you news from the field, highlighting grass roots activities nationwide. HE-XTRA will keep you up-to-date on the latest developments in Washington, D.C. and at your national headquarters.

Publications

You'll receive frequent updates on new publications and audiovisuals available from your professional association...useful resources for your own professional development and for use in your work.

Conventions and Conferences

AAHE offers you a wide variety of programs at national and regional conventions, conferences, and meetings. You'll hear outstanding speakers and meet your colleagues.

Legislative Representation

A full-time staff serves you at national headquarters, keeping you posted on legislative developments in Washington, D.C. and across the nation. And AAHE speaks with a strong, unified voice protecting your interests as a health educator when policy is developed. AAHE also represents you at meetings and policy-making sessions of related organizations.

Leadership Opportunities

You have a voice in shaping health education programs and policies for the future through your participation in committees and task forces. You nominate and elect officers... and become eligible for leadership roles yourself.

Join the leader in health education... Join AAHE.

The American Alliance...On the Move For You

When you join the Association for the Advancement of Health Education, you also become a member of the American Alliance for Health, Physical Education, Recreation and Dance (AAHPERD). More than 43,000 professionals in these fields... teachers, administrators, counselors and others...receive valuable member benefits, including:

Journals — your choice of up to three outstanding selections:

•*Journal of Physical Education, Recreation and Dance (JOPERD)* — 9 issues each year of this award-winning journal cover current trends, news and the latest materials and methods.

•*Health Education* — 6 issues each year feature outstanding articles, the latest news, research abstracts, teaching ideas and book reviews.

•*Research Quarterly for Exercise and Sport* — 4 issues each year highlight new and original research, literature, technology and methods.

Update — your monthly newspaper brings you the latest news in your field, book reviews, association developments, a calendar of events and current job openings.

Conventions and Conferences — national and district conventions, as well as state and local conferences provide ideal opportunities for you to make contact with your colleagues ...hear outstanding speakers...and see the latest in publications, equipment and other materials.

Insurance and Professional Liability Plans — available only to members at low cost.

Also...professional publications and audio-visuals, a job placement service, consultant services, travel plans and much more.

AMERICAN ALLIANCE

HEALTH
PHYSICAL
EDUCATION
RECREATION
DANCE

American Alliance for Health, Physical Education, Recreation and Dance
1900 Association Drive
Reston, Virginia 22091
(703) 476-3400

What Is The American Alliance?

The American Alliance for Health, Physical Education, Recreation and Dance (AAHPERD) is a non-profit association representing professionals in:

- physical education
- sports and athletics
- health and safety education
- recreation and leisure
- dance

More than *42,000* teachers, administrators, researchers, coaches, students and others belong to the American Alliance. Founded in 1885, the American Alliance continues its mission to improve our country's programs in these fields...in schools and communities nationwide...to improve the American quality of life.

From its national headquarters near Washington, D.C., the American Alliance provides a strong national voice for its members on legislative issues...and keeps its members and the public aware of legislative development at the local, state and federal level.

What Are The Objectives Of The American Alliance?

- To provide members with opportunities and materials for professional growth and keep them current on the latest issues, trends, technologies and legislative developments.
- To improve professional standards and performance.
- To support and disseminate outstanding research.
- To speak with a stronger, unified voice on common issues.
- To increase public understanding of the contributions to American life made by our professions.

An Alliance For Your Professional Growth

The American Alliance provides you with important professional benefits including:

Award-winning Journals

The Journal of Physical Education, Recreation and Dance — Nine times each year, this award-winning journal brings you outstanding articles on current issues and new methods, trends and materials. Regular features include book reviews, the latest in products, news updates, and information on association events.

Health Education — six times each year, features authoritative articles for elementary through college level educators, working both in the schools and in the community.

Research Quarterly of Exercise and Sport — a valuable resource for research oriented professionals in physical education, athletics and sports. Reports on new and original research, reviews new literature and offers descriptions of new technology and methods. Four issues per year.

Update

This monthly newspaper keeps you up to date on the latest legislative and association developments...the news in your field...and offers you book reviews, new job openings in your field, and notice of upcoming events.

Conventions and Conferences

National and district conventions, plus regional state and local conferences provide ideal opportunities for you to make contact with your colleagues...hear outstanding speakers...see the latest in materials and methods.

Association Membership

You select membership in one or two associations of the American Alliance...you'll receive literature and invitations to attend events specifically targeted to your interests and area of responsibility.

Representation in Washington, D.C.

Your national headquarters works for you on issues of professional concern; speaking with a strong voice for improved programs in physical education, sports and athletics, health and safety education, leisure and recreation, and dance. And, the American Alliance keeps you informed on legislative happenings through Update and your journals.

Professional Publications and Audiovisuals

More than 400 titles...some of the best literature in the field...available to you at low Alliance prices.

Group Insurance Plans

Optional, low cost professional liability, life insurance, disability, and supplemental medical payment plan...available only to members.

Job Placement Service

Available year round to American Alliance members. A placement booth at the national convention enables job seekers to make contact with potential employers.

Consultant Service

Headquarters staff specialists offer assistance to Alliance members on a number of professional concerns including curriculum, programs, administration, facilities, equipment, organization, leadership and public relations.

Leadership Opportunities

You can participate in the decision making on the local, state or national level. Get active in the future of your profession.

And More

Like travel plans, loan-by-mail, and discounts on car rental.

An Alliance For Strength...7 National Associations On The Move For You

National Association for Sport and Physical Education (NASPE), providing national leadership and opportunities to influence policy and direction in physical education and sports programs for teachers, coaches, athletic administrators, athletic trainers, intramural directors and scholars at all educational levels.

National Association for Girls and Women in Sport (NAGWS), serving those involved in teaching, coaching, officiating, administering, training, club sports and intramurals at the elementary, secondary and college levels. The overall goal of NAGWS is to foster quality and equality in sports for women.

American Association for Leisure and Recreation (AALR), founded to promote school, community and national programs of leisure services and recreation education.

Association for Research, Administration and Professional Councils and Societies (ARAPCS), an association which coordinates the activities of the following special interest groups: Aquatics, College/University Administrators, City and County Directors, Outdoor Education, Facilities, Equipment and Supplies, International Relations, Measurement and Evaluation, Physical Fitness, Therapeutics and Student Members.

Association for the Advancement of Health Education (AAHE), representing the interests of professional health educators working in schools, the community and clinical settings.

National Dance Association (NDA), created to promote the development of sound policies for dance education through conferences, conventions, special projects, publications and cooperation with other dance and performing arts groups.

American School and Community Safety Association (ASCSA), representing the professional interests of safety educators and emphasizing sports safety, traffic safety, first aid and injury control and emergency care in schools and communities.

STATEMENT OF DR. MARIAN K. SOLLEDER, ASSOCIATION OF THE ADVANCEMENT OF HEALTH EDUCATION, GREENSBORO, NC

Dr. SOLLEDER. Thank you, Chairman Perkins, Chairman Andrews, and members of the Human Resources Subcommittee. My name is Marian Solleder, and I'm a professor of health education and assistant dean of the School of Health and Physical Education, Recreation, and Dance at the University of North Carolina at Greensboro. I've been a health educator for 25 years, and I currently serve on the national board of directors and the executive committee of the Association for the Advancement of Health Education.

I'm speaking today as a representative of the association, which is an individual association and is composed of health educators charged with the preservation and improvement of health through education.

As a part of the 35,000-member American Alliance for Health, Physical Education, Recreation, and Dance, the Association for the Advancement of Health Education speaks for concerned educators in the area of health education.

First, I would certainly like to commend Congressman Andrews for introducing H.R. 4472, the Older Americans Personal Welfare, Education, and Training Act. Introduction of this bill demonstrates once again his commitment to elderly Americans, and to create solutions to human problems in an era of fiscal responsibility.

As a health educator I am convinced of the need for health education for people of all ages. Change is the nature of life, and our minds, our bodies, and our health needs change as we move through life's stages. Education is and should be a lifetime concern, a lifetime venture, not terminating with formal schooling in our relatively young years.

Lifetime learning about ourselves, health education, is particularly vital to us as we age, for it is during this time that the body undergoes rapid changes which can confuse and tax emotional, physical, and financial resources at a time when such resources may indeed be limited.

As the bill points out, while the elderly make up only 11 percent of the population, they consume 29 percent of the total health care expenditures, and 50.5 percent of the Federal civilian health care expenditures. The elderly consume more over-the-counter and prescription drugs than any other segment of the American population. We know that the current figure of 25 million elderly Americans is growing, and will drastically increase in the future. Health and health care will continue to be major concerns.

The need for health education is obvious. Senior citizens need to be educated about preventative measures they can take which could increase their life expectancy and/or increase the quality of their lives. They need to be participants in their own health care, not just relative passive recipients of medical treatment. They need to have the chance to learn about themselves, and about opportunities for wellness. They need to be allowed to take personal responsibility for their own health and welfare to the extent that they are able to do so. This is what health education is all about.

Although the Association for the Advancement of Health Education is highly supportive of H.R. 4472, we question the exclusion of many health care educators from the provision of health education as outlined in the bill. By restricting the delivery of health education services to schools of public health, the vast expertise and resources of many of the Nation's health educators are left untapped. We think this should not be allowed.

There are currently 23 schools of public health across the United States. Only 14 of these offer public health education degrees. This means that as the bill is now written, only 14 schools nationwide would be available to serve the needs of 3,300 senior centers and the 9 million seniors in their programs.

The resources of health educators are considerably more vast. 302 colleges and universities.

Chairman PERKINS. Let me interrupt you to say that that's the reason we're here; to get some education.

Dr. SOLLEDER. Thank you, we appreciate that. There are 302 colleges and universities across the country that offer health education degrees. Of these, approximately 175 offer specific degrees in community health education. There are approximately 127 institutions offering bachelor's level programs, 83 offering master's level programs, 7 specialist degree programs, and approximately 33 doctoral level programs.

These schools are distributed across the country, and would make the kinds of services that were to be offered and planned considerably more accessable. By including these additional health educators and health education programs in this bill the potential services to the elderly could be increased about sevenfold, and in fiscal times such as these we think it is wise to make use of all possible resources.

We do not believe that Congressman Andrews intended to exclude the additional resources that this additional group would provide.

Chairman PERKINS. That is very clear; not by any means.

Dr. SOLLEDER. The association again commends Congressman Andrews, and we suggest to the subcommittee, we urge the subcommittee to amend H.R. 4472 to include colleges and universities with graduate programs in health education.

We thank you for introducing the bill, Congressman, and we thank you for having this hearing here in North Carolina.

Mr. ANDREWS. Well, certainly, we most sincerely appreciate your assistance. I was just trying to find what you were saying in the bill. Maybe I've overlooked something, but I wasn't aware that it was restricted in any way to the schools of public health, or to the 9 million people who were said to have attended the centers last year. They were cited in some statement I made about it as a good beginning point, showing that this much, at least, is already in place and known to me, but I'm sure there are others.

The bill, I think, actually says "In order to carry out the provisions of this title the Secretary shall enter into agreements with public or private institutions of higher education with capability in public health in order to further the purposes of this act" and I think that's the essence of the language, and therefore, of course, is not restricted.

In any event, the willingness of the distinguished people whom you represent to participate with us is very encouraging. We're not trying to be, hopefully, overly restrictive.

There is, as you know, from certain limitations I have. I happen to chair the committee that has the Older Americans Act, and the Older Americans Act already provides for nutritional services in these senior citizens centers, and therefore it's rather natural. That when I think of ways to expand the services. that might be rendered to senior citizens, I tend to think of senior citizens centers.

Somebody said we are all functionaries, and I'm sure, to an extent, that's true, but, hopefully, we're more than just a functionary. Yet, if we have much impetus to our being, it arises from whatever function we have developed an interest in or feel motivated toward. Mine happens to have been involved with the role I have had with these senior citizens centers. Others think of churches or whatever, and that's not to say their function isn't just as good or perhaps better than mine.

What I was trying to do was avoid some other big, expensive Federal program. I just perceived that if you have 25 million Americans in every crevice and cranny in this great and broad country, and various territories, served by the Older Americans Act, if you went out in the private health care field to hire the doctors and the psychiatrists and social workers and all the people that might need to be hired on a per hour or per diem basis, you would obviously be entering into a program the cost of which just could not be passed through the Congress. So I initially talked with Dean Ibrahim, and because he is the dean of the school of public health, he began to tell me of these 23 schools, and it seemed great to me, and I was aware there are others. I don't know a whole lot about the others; I didn't know a whole lot about his until he told me about them in several meetings. And so that's sort of the nucleus of where I'm going, and hence that's the perception I had.

I also am aware of the danger that of spreading the authority and the responsibility among so many that you just couldn't run it. You know, you've got to have a coach. Somebody has to say who is going to be part of this team and who isn't, and I'm not speaking of any person or group in particular, but there is some judgment about it, and that's why I've tried to limit my conception of it, and obviously I won't ultimately write it alone. My Chairman and many other people will be involved; but, we're trying to keep it somewhat more like a rifle shot than a shotgun. We want to keep our target in sight and keep our ammunition aimed essentially at the target.

The real importance of this bill is to concentrate not only on who does or doesn't participate, for their function, but instead for our senior citizens, and for assisting our institutions of higher education in holding costs to taxpayers.

Thank you for your presence, and we appreciate your assistance.

Chairman PERKINS. Let me congratulate you. I think you've been very helpful to the committee. Your testimony has been very clear and helpful. I don't think I'll take any more time because we have others who will be speaking. Mr. Dean, do you have any questions?

Mr. DEAN. I have no questions. Thank you.

Mr. ANDREWS. Mr. Raley.

Mr. RALEY. Dr. Solleder, in doing the drafting of the legislation, the Congressman was very specific with me to make sure we used a small "p" when we used public health rather than a BIG "p". Would it help, in including the graduate programs you've mentioned, if we used, with public health, community health? In other words, does that describe the graduate programs you've described?

Dr. SOLLEDER. Depending on the particular institution and the type of degree structure under which it functioned.

Mr. RALEY. I guess the point I want to make is that we particularly want to keep standards involved as we do this. You are not opposed to talking about graduate level programs?

Dr. SOLLEDER. Not at all. Health education might very well cover all of what you're trying to cover.

Mr. RALEY. We'll word it to make sure it includes rather than excludes.

Mr. ANDREWS: Thank you most kindly again. I'm sure we'll be in touch with you and your organization. Thank you.

Mr. ANDREWS. Mr. John Denning, vice president of the American Association of Retired Persons from Clinton, NC. Certainly we welcome you here, Mr. Denning.

[Prepared statement of John Denning follows:]

PREPARED STATEMENT OF JOHN T. DENNING, VICE PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS

My name is John Denning and I am the Vice President of the American Association of Retired Persons.

On behalf of the fifteen million members of AARP, I want to thank you, Mr. Chairman, for the opportunity to be here today to discuss one of this nation's most pressing domestic problems: the crisis in the health care system. AARP congratulates you, Congressman Andrews, for calling attention to this difficult problem and for your work to bring more health information and training to millions of elderly Americans.

As a result of years of continually escalating costs, the American people sit poised on a precipice—whether we're saved or fall into the abyss of unaffordable health care, deteriorating health and low quality medicine depends upon whether we can control the cost of health care!

Health care costs are not just rising; they are soaring. The increase is faster than a speeding bullet, more powerful than the authority of government regulators and able to leap over the voluntary effort in a single bound. Health care costs are like a relentless economic Pac-man eating everything in its path. If health costs were a stock that you had invested in just a decade ago, you'd be sitting pretty today because nothing—absolutely nothing—has risen faster. Not labor costs. Not taxes. Not housing costs. Not even energy or defense costs can match the increase in health care costs.

For most employees, health coverage is a prized, but unpriced, fringe benefit. Few even know how much their employers pay for coverage.

But for business, it means big bucks. Corporate America will pay about $84 billion for health insurance this year. That's more than it will pay in dividends. I was surprised to learn that Chrysler Corporation's largest single supplier is Blue Cross/Blue Shield.

The bottom line is a national health care bill of $322 billion. In other words, every American—man, woman, and child—is paying nearly $4 a day for health care. And that doesn't even count the $30 billion or so the government loses in tax revenues by excluding employer-provided health benefits.

The cost of health care to business is becoming a serious factor in our nation's ability to compete. But I represent the AARP—the American Association of Retired Persons—and I'm here to tell you that the cost of health care is threatening the very existence of Medicare.

Medicare costs are going up. By the end of this decade, Medicare will be in the red; by 1995 it will have a deficit exceeding $300 billion. That's a lot of money even by government standards. It's easy to see how the deficit is mounting: 75 percent of

Medicare expenditures are for inpatient services. Since hospital costs have been soaring at two or three times the general rate of inflation for the past two decades, it's no wonder that Hospital Insurance Trust Fund expenditures have far outstripped the Trust Fund's revenues.

The House Budget Resolution includes a 16 percent increase for Medicare. At that rate, the program's costs will double every five years. That presents us—all of us—with some stark choices. We can either double the HI tax rate every five years, slash Medicare benefits, or control the rate of increase in hospital costs. The choices are as simple as that!

Taxes can be raised fairly quickly and benefits (as we have seen) cut immediately, but that doesn't solve the problem of rising health care costs. We must limit the rate of increase in health care costs, especially hospital costs, and encourage more efficient ways of delivering care.

Coming to grips with the inadequacies of our health care system and sustaining the national commitment to accessible, affordable health care is the explosive policy challenge facing society today. AARP intends to be in the center of this debate. Recognizing the need to focus attention on the need for system-wide reform, the AARP Board of Directors and Legislative Council have made health care a top priority for the next several years.

I would like to share with your our developing plans for a nation-wide health care campaign.

The AARP Health Campaign grows out of our concern about the serious health care decisions confronting society and our desire to motivate actions towards the design of an affordable, coordinated and comprehensive health care system. Unless we are successful in moving the debate away from just Medicare, and focusing the public's attention on the need for system-wide reform, basic health care protection for the elderly and many other segments of our population will erode. Therefore, we see the campaign oriented towards two complementary goals. Most immediately, our activities will emphasize the importance of recognizing that Medicare's problems are simply the symptoms of the broader and ailing health care sector in which it operates. Over the long run, our campaign will focus on rationalizing the health care system by moving away from an acute-care orientation towards a more preventive approach.

When this country was developing its health care delivery system, the major cause of disability and death were the infectious diseases such as pneumonia and tuberculosis. Consequently, we built a system designed for the treatment and care of acute, episodic illnesses. The system is and has been effective in this regard. The pattern of illness, however, has changed. Today, chronic health impairments are the primary causes of disability and death. Unlike acute conditions in which the cure is primarily within the medical care system, chronic conditions are not responsive to short term acute intervention, but can be influenced by personal living habits. Experts say that personal lifestyle is the major factor influencing disease today, contributing 50–55 percent to the risk of chronic disease. Medical intervention contributes a mere 10 percent, the environment 25 percent, and genetics 10 to 15 percent. Since individuals with chronic health conditions can take steps which promote their health, health promotion must begin to play a larger role in health care delivery. The potential for a more preventive approach cannot be overlooked. Since 1968 there has been a 2 percent reduction per year in deaths from heart disease. Most experts attribute the reduction to changes in American smoking, eating, and exercise habits and to the national effort to treat persons with high blood pressure. AARP recognized the importance of preventive health care and, through its Health Advocacy Services, has initiated a number of projects to help older people optimize their good health. Many are familiar with the excellent health education programs, available free of charge, on topics such as nutrition, exercise and the wise use of medications. Many have participated in one of the AARP/American Cancer Society education programs on colon-rectal cancer which emphasized the importance of early detection and treatment. Most recently, AARP and the American Red Cross have agreed to work together to conduct health promotion activities in the community.

Similarly, AARP is delighted to be here today in support of legislation to better coordinate the dissemination of vital health promotion and disease prevention information. We enthusiastically endorse the idea of using the nation's public health schools, faculty and students, to educate and train older Americans about health promotion, disease prevention and sensible health habits. The lack of useable consumer information about health and the health care system is a serious weakness in the system. AARP applauds Congressman Andrews leadership in this vital area.

STATEMENT OF JOHN T. DENNING, VICE PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. DENNING. It's a delight to be here, Mr. Andrews. If I were not here at this moment I would probably be out there with that scattergun you were talking about trying to find those quail.

Congressman Andrews, I want to say from the outset that I am delighted to hear some of the comments that you are making relative to interest in doing something without increasing costs, because we do have a tremendous deficit, and all of us are concerned about what we do as it relates to continuing this escalating cost of things, so I think that H.R. 4472 certainly would be a key factor in trying to bring about a health delivery program that would not necessarily increase costs, and I want you to know that my association would like to put you on the team to see if you could help us bring this to the attention of the American people nationwide. So on behalf of AARP I want to thank you, Mr. Chairman, for this opportunity to be here today to discuss one of this Nation's most pressing domestic problems.

AARP congratulates you, Mr. Andrews, for calling attention to this difficult problem and for your work to bring more health information and training to millions of elderly Americans.

As a result of years of continually escalating costs the American people sit poised on a precipice. Whether we are saved or fall into the abyss of unaffordable health care, deteriorating health, and low quality medicine depends upon whether we can control the cost of health care.

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If health costs were a stock that you had invested in just a decade ago you'd be sitting pretty today because absolutely nothing has risen faster; not labor costs, not taxes, not housing costs, not even energy or defense costs can match the increase in health care costs.

For most employees health care is a prized but unpriced fringe benefit. Few even know how much their employers pay for coverage, but for business it means big bucks. Corporate America will pay about $84 billion for health insurance this year. That's more than it will pay in dividends.

I was surprised to learn that the Chrysler Corp.'s largest single supplier is Blue Cross/Blue Shield. The bottom line is a national health care bill of $322 billion. In other words, every American man, woman, and child is paying nearly $4 a day for health care, and that doesn't even count the $30 billion or so the Government loses in tax revenues for excluding employer-provided health benefits.

The cost of health care to business is becoming a serious factor in our Nation's ability to compete, and I'm here to tell you that the cost of health care is threatening the very existence of medicare.

Medicare costs are going up. By the end of this decade medicare will be in the red, and by 1995 it will have a deficit—we're told that

it will have a deficit exceeding $300 billion. It's easy to see how the deficit is mounting. Of medicare expenditures, 75 percent are for inpatient services. Since hospital costs have been soaring at two to three times the general rate of inflation for the past two decades it's no wonder that hospital insurance trust fund expenditures have far outstripped the trust funds' revenues.

The House budget resolution includes a 16-percent increase for medicare. At that rate the program's cost will double every 5 years. That presents all of us with some stark choices. We can either double the hospital insurance tax rate every 5 years, slash medicare benefits, or we can control the rate of increase in hospital costs. The choices are as simple as that.

Taxes can be raised fairly quickly, and benefits, as we have seen, can be cut immediately, but that doesn't solve the problem of rising health care costs, especially hospital costs, nor encourage more efficient ways of delivering health care, and that's the reason I made the comments a while ago. It's really encouraging to see an effort put forth that hopefully will help to bring about a reduction somewhere in the escalating costs.

Coming to grips with the inadequacies of our health care system and sustaining the national commitment to accessable, affordable health care is the explosive policy challenge facing today's society. AARP intends to be in the center of this debate.

Recognizing the need to focus attention on the need for systemwide reform, the AARP board of directors and legislative council have made health care a top priority for the next several years.

I would like to share with you our developing plans for a nationwide health care campaign. The AARP health care campaign grows out of our concern about the serious health care decisions confronting society and our desire to motivate action toward the design of an affordable coordinated and comprehensive health care system. Unless we are successful in moving the debate away from just medicare, and I repeat that, just medicare, and focusing the public's attention on the need for systemwide reform, basic health care for the elderly and many other segments of our population will erode. Therefore, we see the campaign oriented toward two complementary goals.

Most immediately, our activities will emphasize the importance of recognizing that medicare's problems are simply the symptoms of the broader ailing health care sector in which it operates.

Over the long run our campaign will focus on rationalizing the health care system by moving away from an acute-care-oriented system toward a preventative approach. When this country was developing its health care delivery system the major causes of disability and death were the infectious diseases such as pneumonia and tuberculosis. Consequently, we built a system designed for the treatment and care of acute episodic illnesses. The system is and has been effective in this regard.

The pattern of illnesses, however, has changed. Today, chronic health impairments are the primary causes of disability and death. Unlike acute conditions in which the cure is primarily within the medical care system, chronic conditions are not responsive to short-term acute intervention, but can be influenced by personal living habits.

Experts say that personal lifestyle, and you've heard that mentioned here this morning, is the major factor influencing disease today, contributing 50 to 55 percent to the risk of chronic diseases.

Medical intervention contributes a mere 10 percent, the environment 25 and the genetics 10 to 15 percent.

Since individuals with chronic health conditions can take steps which promote their health, health promotion must begin to play a larger role in health care delivery. The potential for a more preventative approach cannot be overlooked.

Since 1968 there has been a 2-percent reduction per year in deaths from heart disease. Most experts attribute the reduction to changes in American smoking, eating, and exercise habits, and to the national effort to treat persons with high blood pressure. AARP recognized the importance of preventative health care, and through its health advocacy services initiated a number of projects to help older people optimize their good health.

Many are familiar with the excellent health education programs available free of charge on topics such as nutrition, exercise, and the wise use of medications. Many have participated in one of the AARP American Cancer Society programs for education on colon rectal cancer, which emphasized the importance of early detection and treatment.

Most recently, the AARP and the American Red Cross have agreed to work together to conduct health information activities in the community. Similarly, AARP is delighted to be here today in support of legislation to better coordinate the dissemination of vital health promotion and disease prevention information.

We enthusiastically endorse the idea of using the Nation's public health schools, faculty, and students to educate and train older Americans about health promotion and disease prevention and sensible health habits.

The lack of usable consumer information about health and the health care system is a serious weakness in the system. AARP applauds Congressman Andrews' leadership in this vital area in the introduction of this bill. Thank you.

Mr. ANDREWS. Thank you very much, Mr. Denning, and certainly we look forward, as with the others, in working with you and your directors or representatives.

First of all, we need your people to help cause the Senators and the House Members from all over the country to get behind this effort and to assist us with it. Otherwise, we won't be able to implement it. As somebody said, you have to be a politician before you can be a statesman. I don't know if that's true or not, but certainly with a program like this you have to get it on the books before we can implement it, so we'll be calling upon you and hope you'll be calling upon us to assist, but first of all we need to get it written properly, then second we need to get it passed, and certainly third to get it implemented, and fourth to keep it going, keep the train on the track for the purposes for which it is intended. Mr. Chairman?

Mr. DENNING. Thank you, and I would like to say to you that we do have a very capable staff, and we'd like to work with you in any way possible.

Chairman PERKINS. I'd just like to compliment you for your excellent testimony, Mr. Denning. It was very interesting, and it's been very helpful to the committee also. Mr. Denning. Thank you.

Mr. ANDREWS. All right, next we have a panel consisting of Dr. Richmond Anderson of Chapel Hill, and Dr. Harry Phillips, likewise of Chapel Hill, and we very much welcome each of you. Come around please.

[Prepared statement of Dr. Richmond Anderson follows:]

PREPARED STATEMENT OF RICHMOND ANDERSON, RETIRED PROFESSOR, UNIVERSITY OF NORTH CAROLINA, SCHOOL OF PUBLIC HEALTH, CHAPEL HILL, NC

I am Richmond Anderson, a recently retired Professor from the UNC School of Public Health and the Carolina Population Center. My training includes a PhD in Biochemistry and Nutrition, an M.D., an approved Residency in Internal Medicine, and a Masters degree in Public Health. My experience includes over 20 years with Rockfeller Foundation programs in public health and the medical sciences, a decade of work on population with The Population Council of New York and the Population Center of UNC, and a period of service with the U.S. Public Health Service. Consultancies have included membership on an international programs panel of the President's Scientific Advisory Committee, and on population and nutrition committees of the World Bank. Perhaps an additional qualification is the fact that I am by quite a number of years, a Senior Citizen, and that I live in a retirement community where I am in everybody contact with many of the elderly and their health problems.

I believe that the proposed Older Americans Personal Welfare, Education and Training Program is sound in principal, feasible in implementation, and potentially beneficial in excess of probable cost. With present U.S. Government supported medical programs emphasizing primarily care during illness, its emphasis on prevention and on health promoting is particularly opportune. The joining of the skills and facilities to two well established, capable and respected organizations promises a degree of cost saving, public acceptance, and operational efficiency not otherwise achievable. It should also offer invaluable opportunities for research and for training of students and of personnel for both agencies.

I am confident that the Schools of Public Health have the capacity to spearhead, coordinate and guide such a program but they will need the cooperation of others, including other university sources, especially schools of medicine, of dentistry, of nursing, or pharmacy, and of social work; also other public and private health agencies and organizations like AARP. I would also emphasize the value of involving the some 4-5000 and very rapidly increasing number of residential retirement communities, most of them belonging to the Association of Homes for the Aging. Particularly relevant would be the 2-300 communities like Carol Woods here in Chapel Hill, which provide continuing comprehensive service and medical care. Residents of these retirement communities could not only benefit from such a program but could also contribute to it since the level of education of many residents is remarkably high, many of them would have the time and interest, and good physical facilities are usually available. I happen to live at Carol Woods and am pleased to say that it has already established relationships with the UNC School of Public Health and with our local Senior Citizen Service Organization.

Many of the health problems of the elderly cannot of course be prevented nor effectively treated, but health education can contribute toward helping them live more actively and comfortably with their ailments, and probably at less cost.

The proposed Act stresses the need to insure that participating older Americans (and I would add those caring for them) be made aware of the health services available in their communities. I am distressed to see how increasingly often it is the old who have to take care of the old; for example, a sexagenarian daughter with limited resources and with her own health problems, having to provide more than full time care for a physically and mentally disordered mother and/or father. Both of these unfortunate parties badly need the help of this program, and also of other as yet unvailable resources which in the long run must, I believe, be developed.

The proposed Act mentions some of the common health problems of the elderly on which the program might focus. There is not time, nor is this the place to add to or expand on these, but the importance of nutrition, and of prudent drug therapy warrants emphasis. The elderly have long been recognized as a risk group for malnutrition and for anomalous drug responses, and recent work has emphasized their inter-

relationships. For example, diet patterns, especially high protein content, and cooking methods can significantly affect the metabolism of some drugs, many foods contain drug related and drug influencing substances, and fasting and even smoking cigarettes affect drug action. Therefore, the elderly, who more than any other group consume prescription and over-the-counter drugs, often unnecessarily and far too frequently to their detriment, need to be especially prudent about their drug use and their nutritional status.

I am continually impressed by the susceptibility of senior citizens, and of course many others, to false and questionable claims of health benefits—this in spite of their intelligence and frequently very high educational levels. This is due in part to their grasping at any chance of cure or remission of their afflictions, but I believe it is also conditioned by their lack of information on criteria for effectiveness. Understanding is especially needed of the fact that the anecdotal examples on which the commercial propagandists primarily rely are not proof of efficacy, and that the exception does not prove the rule. Health education for the elderly could hopefully promote some knowledge of the simple rules of probability, of the placebo effect, of the need for careful testing, caution in accepting exaggerated claims, and of the dangers of overuse of drugs and of some vitamins.

As one who graduated from medical school over 45 years ago and who has worked in many countries where cases of extreme malnutrition are commonplace, I am more aware than most of the miracles of modern drug treatment and of nutrition and vitamin therapy; but billions of dollars are wasted by the elderly on unnecessary, and sometimes harmful, drugs and nutrition supplements.

According to the FDA, about 40% of adult Americans (more in the case of the elderly) take vitamin and mineral supplements daily, commonly well in excess of the Recommended Dietary Allowances. For many their intakes of potentially toxic vitamins, such as A and D, are well above safe levels. Effective health education regarding drugs, vitamins and other diet supplements, and food selection (inexpensive foods are often among the most nutritious) can notably improve health as well as save a good deal of money. Certainly the elderly need to save money since they still pay about 20% of their medical bills from their own pockets, about the same percentage as before Medicare started in 1965.

One must nevertheless be cautious about expecting an overall cost saving. When the British National Health Service was set up in 1948, the founders had the idea that costs would decrease as people got healthier. They did, but they accordingly lived longer, thereby became increasingly subject to the health problems of older age, required more treatment, and costs therefore rose. But, would we want to deny the elderly these benefits of better care which hopefully will help delay and mitigate the progress of the afflictions that aging flesh is heir to?

STATEMENT OF DR. RICHMOND ANDERSON, RETIRED PROFESSOR FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF PUBLIC HEALTH AND THE CAROLINA POPULATION CENTER

Dr. ANDERSON. I'm Dr. Richmond Anderson. I started out with a degree in biochemistry and nutrition and taught and did research for a while, and then got a medical degree and had a residency fully expecting to go into the practice of medicine, but got diverted to work with the Rockefeller Foundation for many years, and finally ended up here in Chapel Hill with the School of Public Health, and in between got a degree in Public Health at Carolina and Hopkins, and I say this only because perhaps my view is a little different, and perhaps a little broader than some of the others who will be testifying.

I believe that the proposed bill is sound in principle, feasible in implementation, and potentially beneficial in excess of probable cost.

The present U.S. Government-supported medical programs emphasizing primarily care during illness, in the sense that it's an illness program rather than a health program, and I welcome this emphasis on prevention of illness and promotion of health.

I think this program has value in that it brings together two groups of well established, proven, public accepted organizations. I happen to have had contacts with most of the older schools of public health in the country, and a good many of the younger ones, and I am confident that the schools of public health have the capacity to spearhead, coordinate and guide such a program. But as others have emphasized, they will need a lot of help from a lot of organizations, and I've listed some of them here, but I think most of them have been mentioned.

I would, however, like to mention one other group which I don't think has been emphasized. I am told that there are somewhere between 4 and 500 residential retirement communities in this country. The number is growing so fast that I don't think we can get an accurate number. These are varied, they are in many parts of the country, and are of different types. Most of them are nonprofit, and they do have an organization, the Association of Homes for the Aging, which can give some coordination. We have one here in Chapel Hill, where I happen to live, called Carol Woods, and it is among the 3 to 400, I believe, which give continuing care; medical care and various other types of care.

I must admit I am amazed by the degree of education of some of these people. They are people who are interested, some of them have the time, and I think they would be a resource in addition to a group which would especially benefit.

I think we must recognize the fact that many of the problems of the elderly cannot be prevented, nor can they be cured, and I think we must emphasize the fact that one of the biggest functions of a program like this will have to be to help people live with their afflictions. A great deal can be done with this, and I think it can also help reduce costs, as I will refer to later.

There are already some pamphlets coming out on how to live with this disease or that disease, and I think this should be one of the most profitable functions.

I note that the act expresses a need to assure that older Americans are aware of the health services available in their communities. I think this is especially important, and not only for the people needing the care, but for the people giving the care.

I am impressed and distressed how among my own relatives and friends, more and more it's the old and decrepit who are taking care of the older and more decrepit. For instance, a 65-year-old daughter who is not very well herself and has very limited resources trying to take care of an 80- to 90-year-old father or mother. They are overwhelmed, they are very busy, they don't even have time to go out and look to find where the resources are, and I think if some mechanism can be found to put in place to help these people it should be done. It's a 48-hour job taking care of some of these people. Unless you've been through it you don't know how bad it is. And if they can be put in touch with these resources that would be a great help. I think we've also got to develop some more resources to take care of this group, but I think this program can help.

The bill mentioned a number of afflictions which could be helped. I would like to stress two; one is nutrition and the second is drug therapy. We aged are notorious for being a risk group for mal-

nutrition and a risk group for drug therapy. And I'd like to emphasize how closely these two are connected. There has been some very interesting work on how much diet affects the action of drugs. In other words, under certain conditions of nutrition you need more, and under others you need less, and the two are so connected that it indicates that we have to be very careful about the nutrition and about the use of drugs.

I am also impressed by the susceptibility of senior citizens to false questionable claims of health benefits, and as has been mentioned in the proposed bill, they waste a great deal of money, to me, on unnecessary drugs, and often on unnecessary dietary supplements.

I think we also need to help educators in helping the elderly be a little more critical about these unsupported claims, to make them understand that an antidotal example of a commercial propagandist does not constitute proof, or that an exception does not prove the rule.

I would hope that in some of this education they could teach older people a little more about probabilities, a little more about the need for careful testing, a little more about the need for not accepting exaggerated claims, and also some of the dangers of overuse of drugs. I must admit recently I've seen two of my relatives who are very sensible people become practically crazy because they had a little too much of some of the drugs, and also some of the vitamins.

I must say I'm not belittling the value of nutrition or of drugs. I happen to have graduated from medical school about 45 years ago, and you could count on the fingers of your two hands practically the really effective drugs, and now they're in the hundreds, but this also brings great dangers from some of these drugs.

I've also lived and worked in countries where extreme malnutrition was commonplace; you could almost see it on the street. So I appreciate very much the value of drugs and of nutrition, but I think we need to be a little more sensible about this.

I'll not go into figures, but I think recent figures of the FDA indicate that something like 40 percent of all Americans, and more of the elderly, take dietary supplements of some kind. A very large number of these take vitamins and minerals far beyond the recommended dietary allowances, and a great many of them take vitamins like A and D which are almost in the toxic level.

How much harm this does I don't know. I'm sure it does some. But at least it would save the elderly a great deal of money if they did not waste their funds on some of these vitamins and other nutritional suppliments and on unnecessary drugs.

The elderly do have the need to save money. We know that the elderly now spend about 20 percent of their personal income on medical care, which is almost exactly the same percentage as it was before medicare. In other words, they are back to where they were. If it hadn't been for medicare they would have been very much worse, but they are in the same stage as they were before.

I would end by warning that we be cautious about this program saving money overall. I'm reminded of the British Medical Service when it was started in 1948, its founders had the idea that the cost would decrease as people became healthier. Well, people did become healthier, and they lived longer, so they were more subject to the diseases of old age and so costs went up. In other words, if

this program does a good job, the program itself, I hope, will not be too expensive, but it will result in other medical things which, in other words, if it does a good job costs should go up some, and I think we have to face this. But I don't think most of you would want to deny us elderly people better care which hopefully will delay and medicate the progress of the afflictions which aging flesh is heir to. Thank you.

Mr. ANDREWS. Very fine, a good statement. Thank you very kindly. Let's go ahead with Dr. Phillips, and then if there are questions of either, the propounder may designate to whom they wish to ask the question. Dr. Phillips, we're pleased to have you, sir.

[Letter submitted by Dr. Harry T. Phillips follows:]

1308 ARBORETUM DRIVE
CHAPEL HILL, NC 27514
December 20, 1983

Congressman IKE ANDREWS,
Chairman, Committee on Education and Labor U.S. House of Representatives.

DEAR CONGRESSMAN ANDREWS: I am Harry T. Phillips, M.D., a recently retired profesor from the School of Public Health at the University of North Carolina at Chapel Hill. I thank you for giving me this opportunity to make a statement on HR 4472.

In 1978, our School initiated a program in aging and I served as coordinator of this activity until my retirement in May, 1983. In 1979, the program was augmented by a project grant from the Bureau of Health Manpower Education of the U.S. Public Health Service. In 1981, the State of North Carolina provided new money to continue the program.

A major objective of our program was to bring together the fields of public health on aging. To this end the School adopted a number of initiatives. Dr. Bernard G. Greenberg, dean at the time, established an advisory committee consisting of academic staff, and representatives of the fields of public health and aging, as well as consumers and the North Carolina General Assembly. New courses on aging for both full time and extra-mural students were developed, and a state-wide survey of health, social, and aging agencies was undertaken to assess the perceived needs for continuing education. In order to stir up widespread interest in aging in the School itself twelve faculty members in several departments were recruited to write chapters in a book titled "Aging: A Public Health Perspective." This book is in process of being completed for publication by a commercial publishing company.

In May, 1983 the School of Public Health, in collaboration with the Orange County Department on Aging, organized a one day workshop for 100 Orange County citizens. The task before the participants was to suggest feasible ways in which the community, with minimal outside help, could make the county a better place for older people to live in. We developed a number of proposals in the areas of Health, social services, environment, and developmental programs. Among these recommendations was a proposal that the Orange County Department on Aging, along with other interested groups, initiate a self care/patient instruction/disease prevention program. One aspect of this activity was to be a generic drug consumer information project. We are now developing the Orange County Education Project on Medication for the Elderly, and I serve as chairman of the implementation committee. The objective of this project is to "increase the ability of the elderly in Orange County to obtain and use their medications effectively and efficiently." We plan to develop and transmit relevant educational materials directly to the elderly, to work through professionals and agencies serving the elderly, and to coordinate with other health education programs.

As a physician and a retired citizen I am acutely aware of the benefits which medications can provide, as well as their potential harmful effects, particularly for the elderly. Older people as a group have many aches and pains, often hope for a magic cure or relief of symptoms, are frequently both credulous and ill informed, and spend more than the average citizen on both prescribed and over the counter drugs. Moreover, the elderly can ill afford wasteful or unnecessary expenditures on medications.

Your proposed amendment to the Older Americans Act would be a boon to the older citizens of this country. You deserve all possible support from the public and the professions who help care for the elderly. As you can see, in Orange County we have already taken important steps to bring together the fields of public health and aging. After all, public health measures were largely responsible for the aging of

America; it should now continue its good work by meeting the challenge we face. The enactment of your amendment will go a long way in assisting us in this important task.

Thank you.

HARRY T. PHILLIPS, M.D.

STATEMENT OF DR. HARRY T. PHILLIPS, RETIRED PROFESSOR FROM THE SCHOOL OF PUBLIC HEALTH AT THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

Dr. PHILLIPS. Thank you. I am Harry Phillips, a recently retired professor of the School of Public Health here in Chapel Hill, and I thank you for giving me this opportunity to make a statement on H.R. 4472.

I'm particularly pleased to be able to do this because we can share our modest experience with you, because at the School of Public Health in the last few years we've been moving in exactly the same direction that is projected by your bill, sir.

In 1978, our school initiated a program in aging, and I served as coordinator of this activity until my retirement in May 1983. In 1979 the program was augmented by a project grant from the Bureau of Health Manpower Education of the U.S. Public Health Service. In 1981 the State of North Carolina provided new money to continue the modest program.

A major objective of our program was to bring together the fields of public health and aging. To this end the school adopted a number of initiatives. Dr. Bernard Greenberg, dean at that time, established an advisory committee consisting of academic staff and representatives of the fields of public health and aging, as well as members of the aging community, as well as consumers and the North Carolina General Assembly.

New courses on aging for both full-time and extramural students were developed, and we undertook a statewide survey of health, social and aging agencies to assess the perceived needs for continuing education.

In order to stir up widespread interest in aging at the school itself 12 faculty members and several departments were recruited to write chapters in a book entitled "Aging: A Public Health Perspective." This book is in the process of being published by a commercial publishing company.

In May 1983 the School of Public Health in collaboration with the Orange County Department of Aging—this is part of the network—organized a 1-day workshop for 100 Orange County citizens. These 100 citizens represented the older citizens themselves, the informal supporters, that's the family members, neighbors and friends, as well as representatives of professions and agencies whose job it was to help take care of them.

The task for the participants was to suggest feasible ways in which the community, with minimum outside help, could make the county a better place for older people to live in. We developed a number of proposals in the area of health, social services, environment and developmental programs.

Among these recommendations was a proposal that the Orange County Department on Aging, along with other interested groups, initiate a self-care, patient-instruction, disease-prevention program. One aspect of this activity was to be a generic drug consumer information project. We are now developing the Orange County Educa-

tion Project on Medication for the Elderly, and I serve as chairman of the Implementation Committee.

The objective of this project is to increase the ability of the elderly in Orange County to obtain and use their medications effectively and efficiently. We plan to develop and transmit relevant educational materials directly to the elderly, to work through professionals and agencies serving the elderly, and to coordinate with other health education programs.

As a physician and a retired citizen I am acutely aware of the benefits which medications can provide, as well as their potential harmful effects, particularly for the elderly. Older people as a group have many aches and pains and often hope for a magic cure or relief of symptoms. They are frequently both credulous and ill-informed, and spend more than the average citizen on both prescribed and over-the-counter drugs.

Moreover, the elderly can ill-afford wasteful or unnecessary expenditures on medications. As has been said before, it's important to involve the elderly themselves in any health education programs, and they should be an essential part of the planning and implementation process. This should not be left to professionals, and I think it could be quite dangerous to base a lot of these programs in hospitals where I think the education gets slanted in perhaps the wrong direction.

Preventative programs start in the community, and in such institutions as the multipurpose centers. Your proposed amendment to the Older Americans Act would be a boon to the older citizens of this country, and you deserve all possible support from the public and the professionals who help care for the elderly.

As you can see, in Orange County we have already taken important steps to bring together the fields of public health and aging. After all, public health measures were largely responsible for the aging of America, and it should now continue its good work by meeting the challenge we face. The enactment of your amendment will go a long way in assisting us in this important task. Thank you very much.

Mr. ANDREWS. Well, as they say, all's well that ends well. That's an excellent statement, especially the conclusion, Dr. Phillips. Thank you very much. Some of the things you said are certainly worth pursuing, and I may well try to get in touch with you, with each of you, for that matter, as time goes along. But I don't believe I'll go into those matters at the moment. If there is nothing else, our chairman is going to have to leave us shortly and I want him to hear Dr. Ibrahim and the rest of our witnesses.

Chairman PERKINS. Let me say that I've enjoyed your testimony immensely, and both of you have been very helpful to the committee.

Mr. ANDREWS. Dr. Michel Ibrahim, the Dean of the School of Public Health here at the University of North Carolina at Chapel Hill. Certainly, we welcome you.

I might just say just a word here—something about where this all came from and why, maybe, I conceived the program as I have. I suspect my own mother had a lot to do with acute awareness of some of this, and some from a longing to define some sort of an answer. Some 2 or 3 months ago, on a Friday afternoon, I rushed

through traffic—didn't get a speeding ticket, I'll assure you—and got to the airport in Washington with scant time left to get on the last flight down here for an urgent matter, and there was Dean Ibrahim whom I scarcely knew at all. I knew of him. I knew something of his distinguished reputation, but frankly I didn't really know him. Anyhow, we wound up sitting together on the plane flying down, and if we didn't already, we soon knew each other. We had a discussion of his work in the School of Public Health, and somehow or other by the time we got off the plane, I was jotting down a rather remote list of what we later did here. As I continued to think about it, I became somewhat excited as to the idea's potential. I eventually called Dr. Ibrahim, and he was kind enough to permit me to visit with him in the school, and I enjoyed that very much.

I spent a portion of the day with him, and then with others. I might say, I slipped around behind your back, Dean and I talked with some others here at the university in the school of medicine and otherwise, and somehow or other within a week or so this all began to gel in my mind.

So if I have certain prejudices about the way I tend to conceive of this being, I guess it's by reason of its origin, and Dr. Ibrahim, you've going to have to share credit or blame, as the case may be, for having been a major, major contributor to whatever I eventually envisioned and which I hope to see become a great program in this country.

Chairman PERKINS. Let me interrupt you at that point, Mr. Andrews, and state that I think you're getting the type of testimony here today that will enable you to work this out. Naturally, we'll all work together and make any contributions that we can that will certainly guarantee the passage of the bill. Undoubtedly, there is considerable more work to be done, but we're getting so many outstanding ideas here, and the testimony has been very helpful. I think we could take this testimony alone, get in there and have a lot of discussion, make some refinements, and base a bill on it. I just, again, want to congratulate you for obtaining this idea and pursuing it. I know you're going to pursue it until it becomes law. I know your perserverence in the past, and you've made so many contributions. I'm just as sure as we're all sitting here today that this bill is going to become law with the help of all of these good witnesses. Go ahead.

Mr. ANDREWS. Thank you sir.

[Prepared statement of Dr. Michel A. Ibrahim follows:]

PREPARED STATEMENT OF MICHEL A. IBRAHIM, M.D., DEAN, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

Mr. Chairman, and members of the Committee, I am Michel A. Ibrahim, M.D., Dean of the School of Public Health at the University of North Carolina, Chapel Hill. I am appearing here today on behalf of our School of Public Health and the National Association of Schools of Public Health. The president of the Association of Schools of Public Health, Dean William Bridgers, will be pleased to testify before this committee when hearings are held in Washington. I appreciate the opportunity to testify on behalf of this legislation. We would like to congratulate Congressman Ike Andrews, members of the committee, and the cosponsors of the legislation on their efforts to recognize the concept of health education, health promotion and disease prevention as an effective way to improve the health and well being of older Americans as well as to help control the rising costs of medical care.

The legislation H.R. 4472 to amend the Older Americans Act of 1965 by adding a new title relating to health education, health promotion and disease prevention programs to be offered to older Americans at senior citizen centers throughout the country is a commendable step forward in the right direction. We are aware of the increasing size of older Americans in this country, as well as the magnitude of the burden of illness of this segment of the population. The elderly makes up to 11 per cent of the population—that is about twenty four million individuals—and over the next fifty years the elderly will make about 17 per cent or 15 million people. It is estimated that Americans over age 65 represent one out of every five U.S. households. The continued increase in absolute and relative terms of the elderly is due to decreases in mortality coupled with declines in fertility. Therefore, the number of older persons and the proportion of older to younger persons have increased. A useful measure used by demographers is a measure of dependency which is the ratio of the elderly population to the work force. This ratio has grown from 12 per cent in 1940 to 20 per cent today. In addition, the sex composition of the elderly has changed in that today there are only seven men to ten women. The three leading causes of death among the elderly continue to be heart disease, cancer, and stroke which account for three out of every four deaths in this population. In addition, accidents, arthritis, depression, loneliness, saddness, dependency, and isolation contribute immensely to the burden of illness in the elderly.

It is known that many of the causes of these conditions lie in people's behaviors. Many of these behaviors lend themselves to change that is accompanied by changes in the burden of illness. Information is lacking for other behaviors, relative to methods of changing such behaviors and consequences of the change. However, we know enough to begin a program of emphasis on primary prevention through health promotion and practice of healthful behaviors. Several studies have shown that certain practices are associated with increased risk of mortality from a number of conditions. Specific practices which have been found to be associated with mortality and morbidity include physical inactivity, poor diet, overweight, irregular or insufficient sleeping patterns, nonuse of seat belts, and substance abuse. In addition, factors that contribute to poor health among the elderly population include noncompliance with medication, interaction among various drugs, and social isolation, anxiety, loneliness, and depression.

There has not been a strong national policy on preventive measures—mostly lip service. It's known that only four per cent of the federal health dollars are spent on prevention. The current interest in Congress in the establishment of health promotion and disease prevention centers is an excellent beginning. The establishment of these centers could provide useful links with the proposed activities outlined in your legislation. Preventive services in senior citizen centers could be easily accomplished since there is an established network of facilities that would lend itself effectively for this purpose. The best way to proceed, perhaps, is to develop a number of systems which would allow demonstration projects to be carried out on a pilot basis whereby the effectiveness of the various interventions are judged. Schools of public health and other academic centers in the country could participate meaningfully in the planning, design, and evaluation of these pilot demonstration programs. As the benefits from these programs are documented and the cost of the service is determined, service programs may be implemented on a gradual basis throughout the country. Local health departments and other service agencies should be in a good position to provide the actual service. Faculty and students from schools of public health and other academic centers could provide the information base, design the educational modalities and materials, estimation of the effectiveness of these programs, and appropriate recommendations for further steps.

The particulars of this legislation will be refined after further study, and I am confident that the end result would be a legislation that benefits our older citizens. A quote from the 1981 White House Conference on Aging sums up the issues nicely.

"Emphasis should be placed on developing and disseminating educational materials for the elderly, as a component of health promotion efforts by Federal, State and local governments, as well as private entities.

The health policy of the Nation should be to:

a. Improve the health of all Americans, especially the elderly;

b. Contain health care cost; and

c. Focus attention on health promotion and disease prevention.

Additional consideration needs to be given to the benefits the elderly can derive from behavior and lifestyle modifications within individual control.

Information regarding appropriate patterns and probable benefits need to be made a part of health education for the elderly and for those who serve them.

Restructure the health care delivery system so that preventive medicine and wellness are primary objectives and take immediate action to place temporary limits on the rate of increase in hospital costs. Emphasis should be given to a comprehensive review of prevention-oriented screening procedures for the elderly to determine their medical efficacy. In addition, attention should be given to the cost-effectiveness of such procedures. Results of that review need to be widely disseminated to the elderly and to health professionals, to better target prevention efforts and to provide the basis for considering what services are cost-effective from the viewpoint of the individual, the health service delivery system, and third-party payers."

Mr. Chairman, and members of the committee, we urge you to consider this legislation in the most serious way possible. We are pleased that you are holding hearings on a bill that deals with health promotion/disease prevention which would ultimately help in reducing the costs of medical care as it prevents or postpones sickness. These objectives can only be achieved through systematic efforts and legislations that would have to be introduced and pushed ahead as vigorously as possible. We are most willing to work with you and with the committee staff to do anything we can to achieve your objectives.

I'll be honored to answer any questions.

STATEMENT OF DR. MICHEL A. IBRAHIM, DEAN, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

Dr. IBRAHIM. Thank you, Mr. Andrews, for your kind words, and Mr. Perkins, Mr. Dean, and Mr. Raley. I am appearing here today on behalf of our School of Public Health here in Chapel Hill, as well as the National Association of Schools of Public Health. The president of the Association of Schools of Public Health, Dean William Bridgers, will be pleased to testify before this committee when hearings are held in Washington. However, he asked me to speak today on behalf of the association as well.

We appreciate the opportunity to testify on behalf of this legislation. We would like to congratulate Congressman Andrews, members of the committee, and the cosponsors of the legislation on their efforts to recognize the concept of health education, health promotion, and disease prevention as an effective way to improve the health and well-being of older Americans, as well as to help control the rising costs of medical care.

The legislation, H.R. 4472, to amend the Older Americans Act of 1965 by adding a new title relating to health education programs to be offered to older Americans at senior citizens centers throughout the country is a commendable step forward in the right direction.

We are aware of the increasing size of older Americans in this country as well as the magnitude of the burden of illness of this segment of the population. We know that they make up about 11 percent of the population, which adds up to 25 million; but over the next 50 years the elderly will make up about 17 percent of the population. It is estimated that Americans over age 65 today represent 1 out of every 5 U.S. households. The continued increase in absolute and relative terms of the elderly is due to decreases in mortality coupled with declines in fertility. Therefore, the number of older Americans and the proportion of older to younger persons have increased. A useful measure used by demographers is a measure of dependency, which is the ratio of the elderly population to the work force. This ratio has grown from 12 percent in 1940 to 20 percent today, and it promises to grow even higher. In addition, the sex composition of the elderly has changed in that today there are only seven men to ten women. The three leading causes of death

among the elderly continue to be heart disease, cancer, and stroke which account for three out of every four deaths in this population. In addition, accidents, arthritis, depression, loneliness, sadness, dependency, and isolation contribute immensely to the burden of illness in the elderly.

It is known that many of the causes of these conditions lie in people's behaviors. Many of these behaviors lend themselves to change that is accompanied by changes in the burden of illness. Information is lacking for other behaviors relative to the methods of changing such behaviors, and consequences of the change. However, we know enough today to begin a program of emphasis on primary prevention through health promotion and practice of healthful behaviors. Several studies have shown that certain practices are associated with increased risk of mortality from a number of conditions. Specific practices which have been found to be associated with mortality and morbidity include physical inactivity, poor diet, overweight, irregular or insufficient sleeping patterns, nonuse of seat belts, and substance abuse. In addition, factors that contribute to poor health among the elderly population include noncompliance with medication, interaction among various drugs, and social isolation, anxiety, loneliness, and depression.

There has not been a strong national policy on preventive measures—mostly lipservice. It's known that only 4 percent of the Federal health dollars are spent on prevention. I know that a bill has passed the Senate and I know it's now being discussed in the House to establish centers for health promotion or disease prevention. The bill speaks of 75 centers, but the House bill speaks of 13 centers, and it will eventually go to conference, and we don't know how many centers will be approved; maybe, say in the order of 20 centers. These centers for health promotion and disease prevention throughout the country will provide useful links with the proposed activities outlined in your legislation. Preventive services in senior citizens centers could be easily accomplished since there is an established network of facilities that would lend itself effectively for this purpose. The best way to proceed, perhaps, is to develop a number of systems which will allow demonstration projects to be carried out on a pilot basis whereby the effectiveness of the various interventions are judged. Schools of public health and other academic centers in the country, such as schools of medicine and schools of nursing, allied health sciences and others, could participate meaningfully in the planning, design, and evaluation of these pilot demonstration programs. As the benefits from these programs are documented and the cost of the service is determined, service programs may be implemented on a gradual basis throughout the country. Local health departments and other service agencies should be in a good position to provide the actual service. Faculty and students from schools of public health and other academic centers could provide the information base, design the educational modalities and materials, estimate the effectiveness of these programs, and provide appropriate recommendations for further steps. The particulars of this legislation, as you pointed out, Congressman, will be refined and fine-tuned as time goes along, and I'm confident that the end result will be legislation that benefits our older citizens.

37-680 O—84——6

And there is a statement which I will not read, but which I would like to make reference to, from the 1981 White House Conference on Aging that sums up these issues very nicely, which indicates an emphasis on prevention and having a health policy for the Nation that emphasized this approach. And it talks about the benefits to the elderly that could be derived from changing behaviors, and so on and so forth. So here is a panel of distinguished people called in by the White House in 1981 which has spoken to similar issues, like your proposal.

Congressman Andrews and members of the committee, we urge you to consider this legislation in the most serious way possible. We are pleased that we are holding hearings on a bill that deals with health promotion, disease prevention, which would ultimately help in reducing the costs of medical care as it prevents or postpones sickness. These objectives can only be achieved through systematic efforts and legislations that would have to be introduced and pushed ahead as vigorously as possible.

We are most willing to work with you and with the committee staff to do anything we can to achieve your objectives, and I'll be happy to answer any questions. Thank you very much.

Mr. ANDREWS. Thank you most kindly. I have so many that I just won't go into them today, but I certainly invite you and your faculty, your staff, or whomever might be at your disposal, and others, to begin to help us get some detail before the committee. I know it's going to be hard to sit down and lay out all of the minute details, and yet somebody has to do it. I don't know that the law will be that specific, but I would like, if not in the law itself, perhaps in the record that accompanies it, to have that. Somebody is going to have to do that, and certainly, I'll look to the appropriate schools or departments in the institutions of higher education to take, to say the least, a leadership role in defining for us just what we need to accomplish the task. Needless to say, there is going to be some cost, but I've said it before and I'll say it again, and hope you will begin to consider seriously whether academic credit could be extended from the appropriate schools to graduate students who participate in the program satisfactorily. Can graduate students be certified, and by whom? We want to have a program wherein only those who are certified as to their competence, as to their interest, as to their devotion to this concept—including the preparation—are involved in the instruction, follow-through, and evaluation. How could we make provisions that would enhance the probability of your willingness to give course credit? In other words, I think if we make it too nebulous, you probably would consider that you couldn't do that. I believe you told me that in order for it to serve a real purpose for a teaching mechanism, there would have to be, among other things, evaluation with some standard of what that would consist of, to be determined, I presume, by the institution itself and not by law. But there will have to be some cost, obviously, if people are to diverse from your school hither, thither and yon. There are travel costs; there's preparation costs if you produce slides or other teaching mechanisms, for example. So I'm aware there will be costs.

I presume that our bill will eventually say what will cost what, without giving such exact figures, and then it becomes a matter for

the Appropriations Committee. But somewhere somebody has to come up with the details; how many pilots project will we have? How many will participate? How long will the pilot run before the program is started nationwide? We're not going to necessarily name the number, but we're going to say certainly somewhere between 5 and 20. Twenty is probably as many as we could do, and anything less than five would not give an adequate demonstration of capacity or ability.

So begin, if you will, to develop some facts and figures and numbers in order to begin to perceive the problem and solution.

You spoke about the White House Conference on Aging. If my memory serves me correctly, immediately behind you is a very distinguished person in the audience who was a member of that White House Committee, or Conference on Aging back in 1981, a close personal friend, and a former mayor of the city of Raleigh, Isabelle Cannon, who is even yet working with a large number of senior citizens in North Carolina for most worthwhile purposes. I hope this will be one of your purposes, Mayor Cannon, in the near future. We're glad to have you with us.

There is also an integral part of this, which we're not really dwelling on particularly here today. We're primarily talking of four things we think we basically need. It's just a skeletal view, but we need the teachers, the material to be taught, the classrooms, and the students. We're basically talking today about who should do the teaching and what should be taught. But in the near future, we will be having hearings elsewhere, and, while any of this is appropriate in any hearing, we will be focusing more on where to teach and what the classroom shall consist of. Again, I perceive the nucleus as being the senior citizens centers throughout the country.

I also see Ann Johnson, a close and dear friend, back there. I don't know why you're on the back row, Ann, but be that as it may, Ann Johnson is a very distinguished person in the field of senior centers. She operates eight such centers, I believe, in Durham and lives in Chapel Hill. Ann is outstanding in that field, and we'll be looking forward to hearing from you.

Dean, again we thank you. Mr. Chairman.

Chairman PERKINS. Thank you very much, Dean, you've been very helpful to us, and we appreciate your testimony.

Mr. ANDREWS. Mr. Dean.

Mr. DEAN. I just have one question. You noted that you see a role for students in this area. In your detailed recommendations to the committee I would be interested to know if you see a role for college workstudy in helping students get compensation for their participation. I would be interested in hearing your thoughts on that.

Dr. IBRAHIM. Do you mean financial compensation?

Mr. DEAN. Yes; under the college work-study and student financial aid programs, students are paid to help finance their college educations by participation in work in their communities. I'm wondering if you see a role for utilizing college work-study students in this program.

Dr. IBRAHIM. I think I do, and the particulars of involving students, whether college work students or graduate students, in

schools of public health and academic centers need to really be looked at with the faculty of these groups and worked out to make the experience an educational experience for these students, and that's what Congressman Andrews was talking about giving academic credit for, and so it has to be an integral part of the educational experience and would include college work students as well as others.

If you're speaking of the 3,300 centers, eventually when we go out and blanket the whole country we would need a lot of help from a lot of people.

Mr. DEAN. Thank you very much.

Mr. ANDREWS. As I said earlier, I hope, in the legislation, we don't do any harmful dictating by law what the scope and role of the institutions of higher learning of any of its various schools and departments should be or is. Certainly, we want to avoid that, and yet, we want to provide you with whatever facilities are available through legislation to further your successes in your endeavors. We want to see that through this legislation we don't, by way of Federal legislation, begin to mandate the academic scope or assignment or performance. Then, if you will help me, if you ever see us sliding into that, please throw up the red flag, because we don't want to do that.

Dr. IBRAHIM. I'll throw my body in front of you.

Mr. ANDREWS. Yes, thank you.

Dr. IBRAHIM. Just one more quick comment, because I'm very pleased personally for this legislation to happen because between 1964 and 1971 I was in Buffalo in a medical school faculty, and then later in the Erie County Health Department, and we ran at the time what we called "well-aging clinics," modeled after well-baby clinics. It was funded by the health department, and to my horror—we did not give any medicine, we did not treat people, we just simply practiced what you might call health education or health promotion—and 3 years after operating such centers they were closed and the money was not forthcoming, and we couldn't really believe why, and this was almost 20 years ago. So it took 20 years for me to participate in an activity which I think is really 20 or 30 years overdue. And you have our blessings.

Mr. ANDREWS. Thank you, Dean. Again, I appreciate your contributions, past, present, and future.

Dr. IBRAHIM. Thank you very much.

Mr. ANDREWS. Next then, Dr. Harvey Cohen, director of the center for the study of aging and human development, Duke University Medical Center, Durham, NC. I can't believe we have all these people from the University of North Carolina and only you from the very distinguished university, Duke University. I know you have not only the medical center there, but a particularly distinguished School of Gerontology. Certainly, we don't mean to exclude you, and we particularly welcome you as a representative of Duke University.

[Prepared statement of Dr. Harvey Cohen follows:]

PREPARED STATEMENT OF HARVEY JAY COHEN, M.D., ASSOCIATE CHIEF OF STAFF FOR EDUCATION, DIRECTOR, GERIATRIC PROGRAM, VETERANS' ADMINISTRATION MEDICAL CENTER, DURHAM, NC, AND PROFESSOR OF MEDICINE, DIRECTOR, CENTER FOR THE STUDY OF AGING AND HUMAN DEVELOPMENT, DUKE UNIVERSITY MEDICAL CENTER, DURHAM, NC

Ladies and Gentlemen: I am honored by your invitation to appear here today to present my views on H.R 4472 introduced by Mr. Andrews. As Director of the Duke University Center for the Study of Aging and Human Development, I take special pride in the fact that Mr. Andrews, a representative from our state and area, has taken such a special interest in the problems of the elderly and has shown his committment to this by his active participation with the Select Committee on Aging and Select Committee on Health and Long Term Care. We of course, share with Mr. Andrews the concern for the health and well being of our rapidly increasing pool of elderly Americans.

I also share with Mr. Andrews the feeling that maintenance and improvement of the health of the elderly is of great importance and that continuing education of our senior citizens in many areas, including health, is important and useful. In that regard, I applaud the intention with which Mr. Andrews, I believe, introduced this legislation. However, I feel that there are a number of broader issues related to this legislation that must be seriously considered both with respect to the initial premises involved as well as the implementation.

First, though as I mentioned, I applaud the goal of educating our elderly population with regard to their own health as well as many other issues, it is much less clear, and indeed largely unproven that such education would be expected to have any major impact upon behavior modification, alterations of life style and change in health behavior, and thus disease prevention. This is far from clear in much younger age groups, let alone the senior age group. Moreover, one might suggest that if modifications of life style and health related behaviors were to be attempted, one should certainly start at a much younger age to achieve maximal benefit. Thus, I urge when we consider such programs we seriously consider the goals.

The goal of increased education and awareness for senior citizens is appropriate. Indeed, we at the Duke Center for the Study of Aging and Human Development have been involved in such efforts over virtually the entire 25 year history of the program. For example, the Duke Institute for Learning and Retirement was formulated specifically to offer senior citizens and retirees the option of further education in a wide variety of disciplines, which have often included health related topics. I personally have been invoved in seminars for this group wherein health and aging topics were prominently featured. Moreover, for over two decades the Duke University Council for Aging and Human Development has sponsored a Council Seminar series for the presentation of many health and aging related topics. This has been attended regularly by many senior citizens in our community. We house the core facility for a statewide network of Alzheimer's Disease Family Support groups. This group provides extensive health education for many segments of the population including large numbers of senior citizens. In collaboration with the Coordinating Council of Senior Citizens in Durham we have surveyed senior citizens in some of our senior citizen centers to determine their desires with respect to education. In fact, one of the highest priorities on their list was health education.

I believe that it is reasonable to expect that as we meet some of these preceived needs of the elderly population, they will feel better about themselves, in many instances they will feel in better control of their own lives, and often perhaps, have better self images in those cases where self image has been lost to some degree. However, if the goal is to substantially alter life style and health behavior through this mechanism, I believe we are on much shakier ground. Thus, I think we should keep clearly in mind what our goals are in implementing such programs and be quite sure that the goals are compatable with the expected outcomes. For these reasons, if such a program is to be implemented, it is crucial that an evaluation component, related to the outcomes proposed, by built into the proposal.

My other major reservation has to do with implementation. I believe that the legislation as currently written may be far to restrictive. If indeed, we wish to get this job done, then it is as Mr. Andrews has indicated, a large job. Also, as Mr. Andrews has indicated, it could easily become a very expensive job. However, I presume that the legislation will be written in such a way that the costs will be clearly indicated and that a ceiling will be placed so that a maximum will not be exceeded. If this is done, and I surely believe that it should be, then I beleive that the implementation should be left open to any institution, school or program of the health professions that can demonstrate the interest, willingness, and ability to provide the service

within the cost guidelines provided by the regulations. I do not believe that we should be restrictive in the initial legislation as to who should provide this education. There is no intrinsic reason to suggest that such programs could be provided more cheaply by schools of Public Health than they could by many of the other professional schools, equally, or to an even greater extent, already involved in health education. As I have already indicated, much of this is already currently directed at senior citizens.

Furthermore, it has been my impression that individuals seeking education about health and disease prevention tend to do so from those who they preceive are directly involved in the provision of care and maintenance of health that is the health care providers. It strikes me that the institutions in the business of training health care providers, which also have large numbers of faculty and students (in fact considerably in excess of the numbers in Schools of Public Health) might provide a source of educators of even greater relevance to the problem. Moreover, there is a potential major beneficial side effect to be derived from such interactions. That is, we would be training a cadre of health care providers who would have already had a considerable amount of experience in educating the public and the people who are likely to be their patients. When they enter practice, they will have learned a great deal about the elderly and their problems, both medical and social, and be better equipped to handle them. Thus, such education could have the duel purpose of providing health related material to the senior citizen as well as simultaneously having the senior citizen educate our potential health car providers (physicians, nurses, physical therapists, etc.) in the needs, perceptions, and problems of our rapidly expanding pool of senior citizens. I believe that this is of critical importance, since the health care providers that we train over the next several years will be the ones who will have to cope with the expanding burden of illness brought to their medical practices by the elderly.

Once again, I wish to thank Mr. Andrews for his concern for, and dedication to, the elderly of this country, and hope that he and the committee will consider my suggestions for this particular legislation. Thank you very much for having me appear today and present my views.

STATEMENT OF DR. HARVEY COHEN, CENTER FOR THE STUDY OF AGING AND HUMAN DEVELOPMENT, DUKE UNIVERSITY MEDICAL CENTER

Dr. COHEN. Thank you, Mr. Andrews, I appreciate the invitation to appear and express some views on this proposed legislation.

You might say, as the director of the Duke University Center for the Study of Aging, I take special pride in the fact that Mr. Andrews, a representative from our State and area, has taken such a special interest in the problems of the elderly, and has shown his commitment to that by his participation on the various House Committees. We share his concern for the health and well-being of our rapidly increasing pool of elderly Americans.

I also share with Mr. Andrews the feeling that maintenance and improvement of the health of the elderly is of great importance and that continuing education of our senior citizens in many areas, including health, is important and useful, and in that regard I applaud the intention with which Mr. Andrews introduced this legislation. However, I feel that there are a number of broader issues related to this legislation which must be seriously considered, both with respect to the initial premises involved as well as with the implementation.

First, I believe it's important to educate our elderly population with regard to their own health as well as many other issues. However, it is much less clear and indeed largely unproven that such education would be expected to have any major impact upon behavior modification, alterations of life style and change in health behavior, and thus disease prevention. It is far from clear in much younger age groups, let alone the senior age group. Moreover, one

might suggest that if modifications of life style and health related behaviors were to be attempted, one should certainly start at a much younger age to achieve maximum benefit. Thus, I urge when we consider such programs we seriously consider the goals.

Now, the goal of increased education and awareness for senior citizens is appropriate. Indeed, we at the Duke Center for the Study of Aging and Human Development have been involved in such efforts over virtually the entire 25-year history of the program. For example, the Duke Institute for Learning and Retirement was formulated specifically to offer senior citizens in retirement further educational opportunities in a wide variety of disciplines, including health behavior. I personally have been involved in some of these seminars for this group wherein health and aging topics were prominently features and have found the senior audience extremely receptive to such discussions. Moreover, for over two decades the University Council on Aging and Human Development has sponsored a similar series for the presentation of many health and aging related topics, and we house a CORE facility for the statewide network of elderly diseases and related disorders, family support groups, which provides extensive education for senior citizens and other citizens in this area. In collaboration with the Coordinating Council of Senior Citizens in Durham we have surveyed senior citizens in some of our senior citizens centers to determine their desires with respect to education. In fact, one of the highest priorities on their list was health education, so I think the area is quite on target and quite appropriate.

I believe it is reasonable to expect that as we meet some of these perceived needs of the elderly population they will feel better about themselves, in many instances they will feel in better control of their own lives, and often perhaps, have better self images in those cases where self image has been somewhat lost. However, if the goal is to substantially alter life style and health behavior through these mechanisms, I believe we are on much shakier ground. Thus, I think we should keep clearly in mind what our goals are in implementing the programs and be quite sure that the goals are compatable with the expected outcomes. For these reasons, if such a program is to be implemented, I feel that it is crucial that an evaluation component, related to the proposed outcomes, be built into the proposal and be prominently featured.

Now, my other reservation has to do with implementation. I believe that the legislation as currently written may be far too restrictively written in terms of implementation. If indeed we wish to get this job done then it is as Mr. Andrews has suggested, a large job. Also, as he has indicated, it could easily become a very expensive job. However, I presume that the legislation will be written in such a way that the costs will be clearly indicated and a ceiling placed so that a maximum will not be exceeded. If this is done, and I surely believe that it should be, then I believe that the implementation should be left open to any institution, school or program of the health professions that can demonstrate the interest, willingness and ability to provide the service within the cost guidelines as suggested by the legislation. I do not believe we should be too restrictive in the initial legislation as to who should provide the education. There is no intrinsic reason to suggest that such a program

could be provided more inexpensively by schools of public health than they could by many of the other professional schools equally, or to an even greater extent, already involved in health education. As I have already indicated, much of this is already currently directed at senior citizens.

Furthermore, it has been my impression that individuals seeking education about health and disease prevention tend to do so from those whom they perceive are directly involved in the provision of care and maintenance of health that is the health care providers. It strikes me that the institutions in the business of training health care providers, which also have a large number of faculty and students, in fact, considerably in excess of the numbers in schools of public health, might provide a source of educators of even greater relevance to the problem. Moreover, there is a potential major beneficial side effect to be derived from such interactions. That is, we would then be in the position of training a cadre of health care providers who would already have had considerable amounts of experience in educating the public and the people who are likely to become their patients. When they enter practice, they will have learned a great deal about the elderly and their problems, both medical and social, and would be better equiped to handle them. Thus, education would have the dual purpose of providing health related materials to the senior citizens as well as simultaneously have the senior citizen educate our potential health care providers, physicians, nurses, physical therapists, and so on, in the needs, perceptions and problems of out rapidly expanding pool of senior citizens. I believe that this is of critical importance since the health care providers that we've trained, or will train over the next several years, will be the ones who will have to cope with the expanding burden of illness brought to their medical practices by the elderly.

Once again, I would like to thank Mr. Andrews for his concern and dedication to the elderly of this country, and to the committee, in the hope that he and the committee will consider some of the suggestions I've made for this particular legislation, which I do feel strikes at an important and worthwhile point. Thank you.

Chairman PERKINS. Dr. Cohen, from your experience in this area, what changes would you make in the legislation? Just give the committee your ideas about that.

Dr. COHEN. The main point as far as the legislation per se is the implementation, and I would broaden the implementation base of that to open the provision of this service to all schools and health professions, any and all schools and health professions that can demonstrate at the time the implementation is proposed that they can provide the service within the guidelines of cost that would, I presume, be set up for this. I presume there will be some particular cost guidelines set, and that within that I feel that any of the professional schools might be able to compete to be able to provide the service.

Chairman PERKINS. And would you let the administrator on aging in the various States make that judgement. or how would you do it?

Dr. COHEN. Well, it would depend a little bit on how you plan implementing the overall legislation. If you intended to direct this to the States for final implementation through the States then

well, let me back up. I was viewing this somewhat more on the national scope as a competition for the programs to be implemented, and in that setting I was envisioning that a proposal would be made by a given school or group as to how they would carry out this educational program, and that those proposals would be submitted to a review committee. Again, I was thinking nationally, and they would then make a decision about whether that proposal was an appropriate one, and I would have that committee make a decision on merit as to which program appeared to be the best one to carry out the mission as set forth in the legislation.

Chairman PERKINS. From the standpoint of cost what would be your suggestion in regard to inaugurating this program?

Dr. COHEN. Specific dollar figures? I really have no idea. I have to be frank with you, it depends, obviously, on which magnitude one wishes to reach. If, in fact, one is going to attempt to reach into each of the senior citizens centers in this country and bite off that entire piece of the action, I have my reservations as to whether it could be done reasonably at almost any cost. I would propose, however, that a more reasonable way to approach this from the beginning would be to set this up with some demonstration programs and select diverse geographical settings, a number of such projects to be implemented at senior citizens centers, in a very limited fashion, and see then what can be done at a given cost, and then see how generalizable it would be.

Chairman PERKINS. Mr. Dean, do you have any questions?

Mr. DEAN. No, sir.

Mr. RALEY. Mr. Chairman, if I may ask a question? Dr. Cohen, in talking about a need for an evaluation component, to which I think we would certainly agree, you made a statement that it is, to this time, unproven that we can make changes in behavior based on health education. Is there specific research that shows that health education cannot make changes?

Dr. COHEN. Oh no; what I said was largely unproven, but you're quite right that there is a great amount of work to be done to determine what sort of modifications can result in health related outputs. I think one of the problems is that it is a difficult area to tackle because we're looking at results that are down the line from the events you're talking about. It's easy, for example, to give a pre-test on something that somebody knows about, some health related topic, or you give a seminar and find that they have learned something. Sometimes they haven't, but you can often find out that they have learned something. Then the next step is the real question; does that translate into altering some health related component that you would have liked to have done. You can educate a lot of people that their health might be better served by not smoking in a given situation, and they may tell you that they learned all of that about a week or so later, but whether you can get them to stop smoking down the line is quite another story, and the information that comes out of many of those programs is that the short-term gains aren't translated into long-term gains. But I agree, there is considerably more that we have to learn, and we shouldn't miss this opportunity to do just that, because otherwise we might miss the opportunity to prove once and for all that we can't make

modifications that translate into bahavior changes and better health, or that we can by means of this mechanism.

Mr. RALEY. That's all, thank you.

Chairman PERKINS. Thank you very much. You've been very helpful to the committee.

Mr. ANDREWS. Now, the next witness is Carolyn W. Capowski. Come around. We're delighted to welcome you here, and you go right ahead.

[Prepared statement of Carolyn W. Capowski follows:]

PREPARED STATEMENT OF CAROLYN CAPOWSKI, FACULTY MEMBER, UNIVERSITY OF NORTH CAROLINA, SCHOOL OF PHARMACY

Thank you, Chairman Andrews and members of the Subcommittee. I appreciate the opportunity to be with you to discuss the subject of health education and training of the elderly. My name is Carolyn Capowski, a faculty member of the University of North Carolina at Chapel Hill School of Pharmacy. Although I am not a pharmacist, I do teach a course in communications skills to pharmacy students. I have also hosted over thirty Cable Television programs on health information and for the last five years a weekly radio program on health care topics.

I have served as faculty advisor to health education campaigns conducted by our students. In the last four years, three of our statewide health education campaigns have earned four national honors. These include two first-place awards and one second-place from the American Association of Colleges of Pharmacy and honorable mention from the Department of Health and Human Services Secretary's Award for Innovations in Health. Our drugs and the elderly campaign won two of these awards. This "Healthy Aging" campaign, conducted in 1982, was a statewide pilot program designed to educate older adults about their medications. The program was planned to serve as a template for similar programs nationwide, whether in schools of pharmacy or other health professional schools.

Attached to this testimony is a copy of an abstract which appeared in the September-October 1983 issue of "Public Health Reports." I mention this campaign to you particularly because numerous methodologies that are similar to those in your Bill were employed:

1. Brochures, a set of slides, and a game for both reinforcement of information and entertainment were developed for group presentations.

2. Newspaper articles and public service announcements on radio and television were used statewide to heighten awareness of problems the elderly have with their medications and to encourage senior citizens groups to request a presentation from the School of Pharmacy.

3. Students and community pharmacists joined together in presenting "Healthy Aging" information in nutrition centers, senior citizens centers, and church and civic organizations.

4. Packets of information on drugs and the elderly were distributed to one thousand pharmacies all over North Carolina.

5. Numerous copies of the educational materials are kept at the School of Pharmacy for loan to any pharmacist or student who would like to give a presentation on medications and the elderly.

Results from the year-long campaign have shown wide acceptance of the program. In the two years since the program there have continued to be frequent requests for presentations which have been honored. One student alone has given fifteen presentations in the Asheboro-Greensboro area. We have learned from our experience that situations are so varied that a pre-planned group presentation is not adequate to cover all questions which surface after presentations. Therefore, as you suggest in your Bill, students should be supervised by those competent in their fields.

It is evident from these activities, Chairman Andrews, that I and the students with whom I've worked share your concerns for the needs of our older Americans. I congratulate you on your efforts with this Bill. I would like to see, however, several key points of the Bill both broadened and evaluated further. Let me specifically address two of these points.

Point I: On page 3, line 13, I would suggest that the inclusion of other health profession schools would immeasurably increase the utility of the Bill. Therefore, in this entire Bill I would encourage you to expand all public health reference to include other health professions. Perhaps an evaluation of the potential contributions of other health professionals may be in order before the Bill reaches its final form.

For instance, to give you an example of what just one of the health professions has to offer, pharmacists are one of the most knowledgeable about drugs, their usages, and their interactions. They are trained in communications skills, how to teach about prescription and non-prescription drugs and to encourage compliance with drug regimens Indeed, during the period of federal capitation funding, the mandate was for the seventy-two schools of pharmacy to address patient-oriented practice.

In addition, there has been long-standing commitment in these schools in programs supported by the Federal Government, by the drug industry, and by the American Association of Colleges of Pharmacy to develop and upgrade existing curricula in geriatric care. Students in all seventy-two schools of pharmacy are taught about drugs and the elderly in their courses. Many schools have already established complete, formal gerontology programs and long-term care residencies. When they graduate, these students will be practicing in the most well-distributed and accessible health profession available. The pharmacy commitment is there; this pool should be tapped. There are other health profession pools which should be tapped as well.

Point II: The second point I would like to address is on page 6, line 6. Congressman Andrews, I would like to see the word "graduate" deleted from the term "graduate students." In my experience, college students in the health professions not pursuing a graduate degree can provide good health information. Also, because the number of students would be expanded to include both under-graduate and graduate students, your training program for the elderly could reach more persons in a cost-effective manner.

In closing, Chairman Andrews, I am pleased to see that in your address to Congress on November 30, 1983, you recognized the need to maintain and improve more than the physical health of the elderly, but their mentaland emotional health as well. This total health picture is another good reason for involving other health professions in training the elderly at the senior citizens centers. I again urge you to examine what all health professionals have to contribute to your efforts in educating our older adults before the Bill is finalized.

Best wishes in your efforts.

Note: The opinions expressed in the above document are my own and not necessarily those of the School of Pharmacy, The University of North Carolina at Chapel Hill.

Attachment: Abstract from Public Health Reports September–October 1983.

C. W. Capowski

Attachment

marketing strategy will be developed for the project so it will be self-sustaining when funding ends. The project will educate young children, others who care for children, and parents to choose healthy behavior that will last a lifetime.

Entry submitted by: University of Kansas College of Nursing. Ms. White's current address: 927 2d Ave., SE, Lemars, Iowa 51031.

Control of Sexually Transmitted Diseases in Homosexual Males

PHILLIP J. SCREEN

Sexually transmitted diseases are endemic in many large, concentrated homosexual communities in urban areas. In addition to traditional sexually transmitted diseases such as syphilis and gonorrhea, there are now exotic tropical diseases such as amebiasis, giardiasis, and other parasitic helminthic infections. Although these diseases have been well documented in the literature, little has been done to control them.

A new methodology called the "three C" approach uses the clinic, the community, and the client as an integral team in controlling the incidence and prevalence of sexually transmitted diseases. The "Clinic" deals primarily with the organization, procedure, and administration of policies affecting the homosexual community and infected homosexual men. The "community" aspect of the program deals with the public relations of the homosexual community and its leaders as they relate to sexually transmitted diseases. The "client" aspect addresses personal hygiene, sexual practices, and education of the homosexual patients in the community.

The format of the "three C" approach is holistic and comprehensive and thus requires determination, much hard work, money, and care. This kind of approach must be used in its entirety in order to be most effective.

Entry submitted by: Yale University School of Epidemiology and Public Health. Mr. Screen's current address: 60 College St., New Haven, Conn. 06510.

Northwestern Medical Student Community Health Program

LEON S. BENSON
MICHAEL D. BENSON
IRWIN G. BROOSKY

Improving the health of inner-city adolescents is the goal of the Northwestern Medical Student Community Health Program. It could be a model for health training institutions across the country. Founded and run by students at Northwestern University Medical School, the program now consists of two components: Horizons and Discovery.

Horizons draws on freshman and sophomore medical student volunteers to make 1-hour presentations to inner-city seventh and eighth grade pupils, emphasizing the importance of hard work in school and good health habits (for example, avoiding alcohol, drugs, and tobacco). The other part of the program, Discovery, consists of two 1-hour presentations by junior medical student volunteers on the subjects of sex education and self-respect.

The volunteers believe that educational attainment and self-respect are crucial to improving adolescent health status. By stressing the importance of self-respect, the volunteers hope to enable the seventh and eighth graders to cope more effectively with the frustrations of growing to adulthood. This approach to preventive medicine has met with enthusiastic response from both Chicago educators and more than 12,000 young people.

Entry submitted by: Northwestern University Medical School. Leon Benson's current address: 9430 Harding Ave., Evanston, Ill. 60203.

Healthy Aging Public Awareness Campaign

DONNA TIDWELL

Approximately 800,000 persons in the age group of 65 and over live in North Carolina (about 11 percent of the population). The fastest growing age group in the State, persons 65 and older, show a high use of prescription drugs. Because of their multiple problems, many must take an average of four to five drugs regularly. The high drug consumption rate and the different metabolism of drugs by the aged create an enormous public health problem that is hardly addressed in the literature or by the health care system.

To address the problem, a pilot public awareness program was conducted in North Carolina. Pharmacy students and practitioners, other health professionals, pharmacy associations, and members of the news media were involved. Students gave more than 300 presentations to the elderly. Presentations included a slide show, a question and answer period, and a game to reinforce the information. Because of high interest in the "Vial of Life" program shown in the slide show, four more counties in the State adopted the program (a medical alert system designed for quick retrieval of information in emergencies).

More than 1,000 pharmacists participated, indicating in store windows their willingness to answer drug-related questions; they also distributed brochures developed for the program. The news media outlined the program's goals on television, on the radio, and in newspapers, reaching a large part of the State's population. This campaign could serve as a model for similar programs nationwide, whether in pharmacy or in other health fields.

Entry submitted by: University of North Carolina School of Pharmacy. Ms. Tidwell's current address: P.O. Box 39052, Raleigh, N.C. 27603.

A Medication Information Card Program for Patients

WILLIAM J. ZUCKER

To improve the public's ability to use prescription drugs safely and effectively, both the Food and Drug Administration and the American Medical Association (AMA) have acted to make information about prescription drugs more available to patients.

Those efforts could be complemented by a program based on the Medication Information Card (MIC). The card would be issued to the patient by a participating physician at a normal office visit. Patients would take their MIC to all future visits, including physicians' offices, emergency rooms, and hospitals. During each visit, newly prescribed medications

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STATEMENT OF CAROLYN W. CAPOWSKI, SCHOOL OF PHARMACY, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

Ms. CAPOWSKI. I really wish to thank you for inviting me to be here. I certainly did not expect that when I called and spoke with Congressman Andrews' office. I just called and expressed an interest in the bill, and was invited to speak. I'm certainly delighted to be here.

My name is Carolyn Capowski, and I'm a faculty member of the University of North Carolina School of Pharmacy. Although I am not a pharmacist, I do teach a course in communications skills to pharmacy students. I have also hosted over 30 cable television programs on health information, and for the last 5 years a weekly radio program on health care topics.

In addition, I have served as faculty adviser to health education campaigns conducted by our students. In the last 4 years, three of our statewide health education campaigns have earned four national awards. These include two first-place awards and one second place from the American Association of Colleges of Pharmacy, and an honorable mention from the Department of Health and Human Services Secretary's Award for Innovations in Health. Our drugs and the elderly campaign won two of these four awards. This was entitled "Healthy Aging." This particular campaign was conducted in 1982 It was a statewide pilot program designed to educate older adults about their medications. The program was planned to serve as a template for similar programs nationwide, whether in schools of pharmacy or other health professional schools.

Now, I've attached to this testimony a copy of an abstract of this program which appeared in the September–October 1983 issue of Public Health Reports. I mention this campaign to you particularly because in encompasses a number of numerous methodologies that are similar to those in the bill which you have suggested.

One, there were brochures on the responsible use of prescription and nonprescription medications, a set of slides and a game for both reinforce and the entertainment of those participants. And these were developed for group presentations.

Now, for cost efficiency I really believe that you need to employ the public media, the print media, the broadcast media. For instance, in our year-long campaign we had newspapers, newspaper articles, public service announcements on radio and television that virtually covered North Carolina, and we have documentation from the statements to say that it did. This serves to help increase the awareness of all persons, not just the elderly, but those who care for the elderly, those who have friends who are elderly and those who hope to become elderly some day, that there is a problem, and this you should prepare for. So the broadcast and the print media help set the awareness. It kind of got people ready to listen.

Then students and community pharmacists joined together to present healthy aging information in numerous centers, and these included nutrition sites, senior citizens centers, church, as Dr. Morrow mentioned, and civic organizations. I think it's particularly important to stress that here our students went into their home communities, they were volunteering their time, they were not required to do this health education, they went into their home com-

munities and paired themselves up with practitioners, pharmacists in the communities, before they went into the different centers to give presentations. This way they knew the areas, they knew the needs of the people, and they even knew some of the participants in their audiences, and this local attachment, I think, helped contribute to the success of the campaign.

In addition, packets of information on drugs and the elderly were distributed to 1,000 pharmacies all over North Carolina. These were available for people to look at, whether or not they were able to attend a presentation, because the facts are, not everybody goes to senior citizens centers, and they do go into pharmacies.

Now, numerous copies of these educational materials are kept at the school of pharmacy for loan to any pharmacist or student, and I might add, any other health professional who might like to give a presentation on medications and the elderly.

Now, results from this year-long campaign have shown wide acceptance of the program. In the 2 years since the program there continue to be frequent requests for presentations which have been honored, and one student alone has given 15 presentations in the Asheboro-Greensboro area. Now, we have also learned from our experience that situations that come up in these presentations are so varied that a preplanned group presentation, no matter how good it is, is not adequate to cover all of the questions that will surface after a presentation. Therefore, we suggest that you have in your bill that students be supervised by those competent in their fields to help resource individuals.

Now, I hope that it's evident that and the students with whom I work share your concerns for the needs of our older Americans, and I congratulate you on the efforts put forth in this bill. I would like to see, however, several key points brought out and evaluated further, and let me specifically address only two of these points.

Point 1: On page 3, line 13, I would suggest that, as many others have today, the inclusion of other health profession schools would immeasurably increase the utility of the bill. Therefore, in this entire bill I would encourage you to expand all public health references to include other health professions. Now, to avoid the shotgun approach, perhaps an evaluation of the potential contributions of other health professionals may be in order before the bill reaches its final form. Now, for instance, I've been with the school of pharmacy for 8 years, so you're going to be hearing about pharmacy for just a second. Just to give you an idea of what this provision has to offer in your health education role, pharmasists are one of the most knowledgable health professions about drugs, their usages and their interactions. They are also trained in communications skills. That's what I teach. No matter what your physician has told you, no matter what your pharmacist tells you or doesn't tell you as you pick up a prescription, the fact remains that there are quite a few prescriptions that are not used effectively. Indeed, during the period of Federal capitation funding, there was a mandate for all 72 schools of pharmacy to address patient-oriented practice. So there has been a growth in this communication skills kind of teaching.

In addition, there has been longstanding commitment in these schools of pharmacy in programs supported by the Federal Govern-

ment, by the drug industry and by the American Association of Colleges of Pharmacy to develop and upgrade existing curricula in geriatric care. Students in all 72 schools of pharmacy are taught about drugs and the elderly in their courses. Many schools have already established complete formal gerontology programs, and long-term care residencies. When they graduate, these students will be practicing in the most well-distributed and easily accessible health profession available. The pharmacy commitment is there, and this pool should be tapped.

Now, beyond the students I also believe that schools of pharmacy should be involved in designing the teaching materials, when you start looking into materials on precription and nonprescription medications. There are other health professional pools which should be tapped as well.

Now briefly, for point, what I'd like to address is on page 6, line 6. I would like you to consider deleting "graduate" from the term "graduate students". In my experience, college students in the health professions not pursuing a graduate degree can also provide good health information, and also, because the number of students would be expanded to include both the undergraduates and the graduate students, your training program for the elderly could reach more persons in an even more cost-effective manner.

In closing, I am pleased to see that in your address to Congress on November 30, 1983, you recognized the need to maintain and improve more than the physical health of the elderly, but also their mental and emotional health as well. This total health picture is, to me, another good reason for involving other health professions in training the elderly. I again urge you to examine what all health professionals have to contribute to your efforts in educating our older adults before this bill is finalized. Thank you.

Mr. ANDREWS. Thank you for sharing your valuable experience with us. I'm very appreciative. Mr. Chairman, do you have anything?

Mr. PERKINS. I just wish to compliment the lady, and I was impressed by her eagerness to get the information out of your bill before she was invited to speak. You've given us excellent testimony, and we appreciate your appearance here today.

Mr. ANDREWS. Now, William Carlton Byrd, Sr., professor of the School of Allied Health and Social Work of East Carolina University, and Dr. Donald Ensley, associate professor for the School of Allied Health and Social Work, with Dr. Jasper Register, likewise an assistant professor of the department of sociology, anthropology, and economics. We welcome all of you gentlemen here, and I see only two of you.

Mr. BYRD. We are very sorry to say that Dr. Register is not with us. We need him, but he had another commitment that he couldn't escape.

Mr. ANDREWS. Well, we very much welcome you, and you may proceed.

[Prepared statement of Prof. William C. Byrd follows:]

SUMMARY OF PREPARED STATEMENT OF PROF. WILLIAM C. BYRD, M.ED., M.P.H., PROFESSOR OF COMMUNITY HEALTH, SCHOOL OF ALLIED HEALTH AND SOCIAL WORK, EAST CAROLINA UNIVERSITY

Experience in the field of public health education, research on aging, and demographic data for rural America suggest that limiting this program to persons served at senior centers would effectively deny benefits to the majority of the elderly. Of the estimated 25 million elderly Americans, only about 9 million were served last year by senior centers.

Experience and research point to the importance of family members as key sources of support for health care and for meeting basic needs for survival. In light of the magnitude of the needs of the elderly in America, it is imperative that an action plan be devised which provides health education and training, not only to the elderly but also to family members and friends. In black families, the age group 18 to 34 appears to be particularly positive in attitudes toward the elderly and many constitute a key resource in providing information to elderly family members.

Churches, civic groups and volunteers need to be mobilized to help meet the needs of elderly persons in their various communities.

Qualified institutions of higher education which have clear capabilities to provide appropriate public health expertise should be utilized to assist county health departments to design and implement demonstration projects in selected communities to carry out the intent of this bill.

We submit that East Carolina University is such a qualified institution.

PREPARED STATEMENT OF PROF. WILLIAM C. BYRD, M.ED., M.P.H., PROFESSOR OF COMMUNITY HEALTH, SCHOOL OF ALLIED HEALTH AND SOCIAL WORK, EAST CAROLINA UNIVERSITY, CHAPEL HILL, NC

My colleagues and I wish to thank Congressman Andrews for his invitation to attend this hearing and share with you some of our interests and concerns. Having received that invitation on December 16, we wish to stipulate that ours is a preliminary draft which we expect to amplify later, after consultation with other faculty members and E.C.U. Chancellor John Howell.

I would like to recognize Dr. Don Ensley of our Department of Community Health and Dr. Jasper Register of our Department of Sociology, both of whom have contributed to these prepared remarks. Also, in the audience is Dr. Mary Rose, Assistant to the Chancellor, and one of the interested persons who will contribute to a later, expanded statement.

My personal input is limited substantially to perspectives which I have developed from many years of professional experience in public health education most of that experience having been in substantially rural areas of North Carolina, Tennessee and West Virginia. Secondly, I come from a background of the practice of public health education, and not one of research. Too, my own views are very much influenced by being a share-cropper's son who remembers the Great Depression and whose own parents died in poverty.

I congratulate Congressman Andrews for the initiative he has taken in recognizing an important facet of health care which has been neglected by third party payors and which is only recently receiving much support as an element of care, "care" having been defined almost exclusively in terms of clinical services, heretofore.

I want to touch upon some of the special problems of the rural elderly, some considerations relating to the black population, and to some of the logistical problems of reaching the rural elderly citizens with the benefits of this new bill.

While there are an estimated nine million elderly served in centers for senior citizens, about sixteen million others are not served by these centers. From the perspective of Eastern North Carolina, this is easy to explain. Over 28% of our elderly have incomes below the poverty level and about 14% of all occupied housing has no automobile [1]. Some elderly are, of course, substantially homebound while many others are busy gardening, baby-sitting or otherwise struggling for financial survival. A serious question, then, is how to bring the potential benefits of this new legislation to more than the few who are served by the existing centers.

From my own experience in public health and community mental health, I have a keen appreciation for the potential involvement of family members, as well as the primary client. There is a great resource in volunteers, civic groups and churches. So, as I think about rural America, minorities and poverty, I see the necessity of mobilizing an array of existing helping hands, with a minimal reliance upon professionals.

Dr. Lowell Levin and others have alerted us to our tendency to promote dependency among clients and to undermine the role of the family (2, p. 64). And Dr. John Fry has noted that in the United Kingdom, minor accidents and episodic illnesses are handled most often, and perhaps best, at the family level, either through self-care or simply doing nothing (2, p. 67).

Again, thinking of the rural elderly, I am concerned about the basics of their environment. In the absence of simple items like handrails, night lights and smoke alarms many elderly people are subjected to unnecessary high risks of injury, long term hospitalization or untimely death. For many, mere information will not be enough. Volunteer or family assistances will be needed if the information is to be put into practice. So, if we expect this effort to actually change lives and living conditions of the elderly we must design an action program which will take the education and information all the way to implementation (or at least provide the opportunity to act on the advice).

Another tremendous potential resource is the developing network of religious television stations, the largest system being the American Christian Television System. The Greenville, North Carolina, affiliate is Channel 14, WXIV which will be able to reach approximately 698,000 households in some 30 eastern counties. In an interview with local station official Tommy Payne, I learned that the ACTS network is already planning programs oriented to the elderly citizens. At this developmental stage, public health professionals can encourage and influence this emphasis in television programming of this new resource. It is reported that about 135 applications for Christian television stations are before the FCC.[5]

Dr. Register has done some research in the area of social gerontology which notes the following:

(1) There may be an important role for young blacks in helping their elderly family members to give positive meaning to these last years of their lives;

(2) Most studies show blacks higher on religious participation than whites;

(3) Adequate minority representation on staffs, and the location of programs in minority neighborhoods are important factors in ensuring use of services by elderly minority persons;

(4) Blacks between the ages of 18 and 64 years of age hold relatively favorable attitudes toward the elderly;

(5) However, the realities of old age among blacks appear to be a disappointment, rather than a fulfillment of earlier expectations.[3]

From Dr. Register's review of the literature and his own research, he suggests "the need for two strategies of intervention that focus upon young blacks: (1) there is a need for educational programs designed to disseminate information to young blacks about the reality of being old and black, and (2) practitioners should develop good working relationship with young blacks whose households include elderly persons * * * ignorance about programs is frequently a reason why aged blacks fail to take advantage of services."[3]

In another work, Dr. Register and his colleague, Dr. Jim Mitchell have further investigated attitudes toward the elderly. Significantly, the most positive attitudes toward the elderly were highest among the age group 18–34.[4] One implication, then, is that young adults may well be the most receptive citizens for receiving and disseminating information about the elderly and they may be an important resource for providing voluntary help for the elderly.

As we have studied the proposed legislation and considered our personal experiences and some of the research, we make the following observations.

A. The very rural nature of our area of the state, the virtual absence of public transportation, the high levels of poverty, and the high percentage of minority persons suggest:

(1) Meaningful encounters for purposes of education, information and training must go beyond the bounds of senior citizen centers, to include churches, civic groups, public health departments, the media and, even, the homes of the elderly;

(2) Substantial emphasis needs to be placed upon targeting other family members as recipients of information, advice and training; and

(3) Minority persons should be substantially represented in the cadre of professional manpower at all levels.

B. Logistical and manpower considerations include the following:

(1) The relatively few schools of public health in the nation are often so far removed from the masses of the elderly (especially the rural elderly) that it can be expected to be excessively expensive in travel and man hours to provide sufficient on-site training and health education directly through these resources;

(2) Experience with the federal Rural Health Initiative for the establishment of viable primary medical care has revealed high levels of dissatisfaction with the

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"rapid" turnover of care providers though many of these work in a locale for one or more years. The even briefer stays which university faculty and students could provide would be destined to incur a lack of credibility and continuity, from the perspective of the clients.

THE ROLE OF HIGHER EDUCATION

In light of these considerations, it is sugested that institutions of higher education with viable components for the delivery of public health expertise be identified for the primary purposes of providing:

(a) Consultation and technical assistance to local agencies for purposes of designing educational and service programs tailored to the needs of selected demonstration communities;

(b) To collaborate with local agencies to conduct needed research and to design methods to evaluate program outcomes;

(c) To upgrade course content to more adequately include practical information and community experiences in the field of aging for both graduate and undergraduate students;

(d) And to identify both undergraduate and graduate majors in appropriate health fields to engage in the work of the selected community demonstration projects, but not as the primary manpower for on-site health education.

FUNDING AND DEMONSTRATION PROJECTS

To accommodate the manpower and logistical considerations at the community level, we suggest the following:

(1) Distribution of funds from the federal level to the Secretary of the Department of Human Resources, within the states;

(2) Grants or contracts from the Department of Human Resources to qualified institutions of higher education to carry out the roles described above;

(3) Grants or contracts from the Department of Human Resources to local public health departments to provide the primary health education, training and community organization activities, with consultation and technical assistance from higher education and with input from other appropriate local agencies. This latter suggestion is based on the traditional role of the local public health department as the primary official agency for promoting and protecting the health of the community. Further, many health departments already have professional health education components and an interdisciplinary staff capable of contributing to both education and clinical health services for the elderly. Identification and management of volunteers, community organization, etc. are traditional activities within public health education.

In support of inclusion of qualified institutions of higher education, we submit that certain schools of allied health are qualified. East Carolina's School of Allied Health and Social Work houses the first baccalaureate program in community health education ever approved by the Society for Public Health Education. Almost all of our faculty hold graduate degrees in public health.

Recognizing the reality of substance abuse within the elderly population, it is noteworthy that the school also has an Alcoholism Program which, for some eleven years, has contributed significantly to the development and staffing of community service programs in North Carolina. Additionally, we have a graduate level concentration in community health within the University's Master of Public Administration degree. We have a Department of Environmental Health with both undergraduate and graduate degrees; many of the skills of that department are relevant to the environmental aspects of residential safety and rural life. We have very able graduate faculty in biostatistics, epidemiology and rural sociology.

In addition, at ECU we have a thriving School of Medicine which is significantly engaged with rural communities.

I thank you again for this opportunity and I hope our suggestions may be useful.

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STATEMENT OF PROF. WILLIAM C. BYRD, M.ED., M.P.H., PROFESSOR OF COMMUNITY HEALTH, SCHOOL OF ALLIED HEALTH AND SOCIAL WORK, EAST CAROLINA UNIVERSITY

Mr. BYRD. Let me say at the outset that I'm going to attempt to abbreviate my remarks in the interest of time. Some of us are getting old enough that we don't need to sit quite this long, including myself.

My colleagues and I wish to thank Congressman Andrews for his invitation. We're delighted to have this opportunity to be with you. I would like to state that ours is a preliminary draft which we expect, and I'm sorry to say without necessarily the approval of our Chancellor, so we may be in a sticky wicket here. We haven't had the opportunity to check it out, but we expect to amplify later, after consultation with other faculty members.

Mr. ANDREWS. We'll certainly welcome that, Mr. Byrd. I apologize for the very brief notice.

Mr. BYRD. Well, we're delighted to have the opportunity, and we'll apologize to the Chancellor later, if we have to.

Mr. ANDREWS. You do that, and you just say what you want to as an individual, and then if the school or your department, on a more formal basis, has further statements, without objection, we'll leave this record open so as to receive and include any official formal statements.

Mr. BYRD. Of course, I'm happy to have Dr. Ensley of our department of community health with us, and I want to credit Dr. Register of our department of sociology as well. Also in the audience is Dr. Mary Rose, assistant to our Chancellor, so we're partly covered.

I will apologize for some personal references here, but my personal input is substantially limited to perspectives which I've developed over the years as a practitioner of public health education. I'm not a researcher, and I don't claim to be, but I've spent a great deal of time in rural areas of North Carolina, Tennessee, and West Virginia, and they are about as rural as you can get. Also, my own background is one of coming from poverty, so I'm an expert on poverty, being a sharecropper's son, and having seen my parents die in poverty.

I want to congratulate Congressman Andrews for the initiative, and I might add, courage, he has taken in recognizing an important facet of health care, which has been too long by third-party payors, and that is education. As you all are probably very much aware, care has been defined largely in clinical terms, and this, we think, has been very limiting in the kinds of services that have been made available to elderly and others.

Before proceeding, I want to interject here something that occurred to me as I was listening to the others. I'm convinced that a major benefit of this legislation will be the education and the reeducation of faculty who too often are imprisoned, if you will, in academia, and by virtue of that distance that so often is the case sometimes we do not have an adequate practical appreciation of what I call the real world. I constantly tell my students that one

day they will be in the real world as opposed to being at East Carolina.

I want to touch upon some of the special problems that we see affecting the rural areas, some special considerations relating to the black population, and some of the logistical problems of reaching the rural elderly citizens with the benefits of this new bill.

From the perspective of eastern North Carolina, we would mention that over 28 percent of our elderly have incomes below the poverty level, and about 14 percent of all occupied housing has no automobile. And eastern North Carolina is virtually without public transportation. We have the added geographical problem of an awful lot of water, an awful lot of creeks and sounds and so forth that make travel difficult.

Some of our elderly are obviously substantially home-bound, and there are many others who are very busy people; busy with pulpwood, gardening, or baby-sitting, or otherwise struggling for financial survival. The serious question, then, is exactly how to bring the potential benefits of this new bill to more of the elderly, and especially to those who are separated by geographic and economic barriers.

From our own experience in public health and community mental health, I want to emphasize that there is, in our opinion, a major potential role for the involvement of other family members, that is, in addition to the primary client, the older person. Also, we believe that there is a tremendous resource in volunteers, in civic groups, and in churches, and certainly this has already been mentioned, in the variety of health care professionals that are already in place in most of our communities. So as I think about rural America, minorities and poverty, I would see the necessity of mobilizing a very substantial array of existing helping hands, and I want to underline this on your copies, with a minimal reliance upon professionals. There went some of the money down the drain. That is to say, if we can really do that, and I believe we can. I think we can reduce costs very considerably.

Dr. Lowell Levin and others have alerted us to the tendency to promote dependency. That is, the tendency on the part of us as the care-giving professionals, to promote dependency among clients, and to undermine the role of the family. Dr. John Fry has noted that in the United Kingdom minor accidents and episodic illnesses are handled most often, and perhaps best, at the family level, either through self-care or simply leaving it alone. I think this is an area that needs to be looked at; the whole area of self-care and increased dependence upon family and friends and local neighborhoods.

Again, thinking of the rural elderly, I'm especially concerned about the basics of their environment, and I believe, in thinking about the question of the validity of education undertakings, in many cases the rather simple manipulation of environmental circumstances can have a very positive effect. In the absence, for example, of such simple things as having handrails to get in and out of the door, railings in the bathroom, if you're lucky enough to have a bathroom. If somehow, those who have to run the risk of walking a hundred yards to outside john could have inside plumbing, in many many instances we would see, I believe, prevention of

broken hips and other kinds of injuries that result in long-term hospitalization, a lot of time in nursing homes, and in many cases untimely death. Exactly that sort of thing happened to my mother, whose injury from a fall led to several years of care in a nursing home, and total disability, and eventual death.

Another tremendous potential resource which is very new, and which is somewhat outside the realm of public health, but it's in the communities, so I think it's something we need to take note of. There is, at this moment in history, a developing network of religious television stations. The Greenville affiliate, channel 14, which is now under development, will have the potential of reaching 698,000 households, and I am convinced that advertisers would not spend the money they do on television if it didn't have some salutary effect upon sales. I know that this developmental stage in the development of these systems that public health and other professionals can at least encourage and influence the emphasis in television programming to include programming that would be informational and beneficial to the elderly.

Chairman PERKINS. Would you also include as a public service to reduce cost for those who wanted to participate in something of that nature?

Mr. BYRD. Yes. The station in Greenville is set up as a private nonprofit corporation. It is tied primarily to the ACTS Program, the American Christian Television System, the initial funding at the programming level, coming through the Southern Baptist Convention. Now, they will be selling advertising eventually, but they also will be developing much of the programming themselves. So if the advertiser wishes to purchase time for a program which is family oriented, then he will pay the price, but the quality of the programming simply will be much better than the typical soap opera, so far as helping family life.

Dr. Register has done some research in the area of social gerontology which notes the following, and I wish he were here to elaborate on this: That there may be an important role for young blacks in helping their elderly family members to give a positive meaning to these last years of their lives. Another point in his research is that adequate minority representation on staffs and the location of programs within minority neighborhoods are important factors in insuring use of services by elderly minority persons.

Interestingly, blacks between the ages of 18 and 64 years of age hold relatively favorable attitudes toward the elderly, and as a matter of fact, the earlier research, I think, the highest positive ratings came from 18 through 34. So it appears that a very interested and favorably inclined segment of the minority population would be young adults who could conceivably be mobilized to help to change some of the circumstances in the lives of their elderly.

As we have studied the proposed legislation and considered our personal experience and some of the research, we make the following observations: The very rural nature of our area of the State, the virtual absence of public transportation, the high levels of poverty and the high percentage of minority persons suggests, one, that meaningful encounters for purposes of education, information and training must include such as churches, civic groups, public health departments, the media, and in some cases, even the homes

of the elderly. That sounds like a big order, but I think if we can substantially address the business of developing volunteer manpower, lay manpower in many instances, that much of the teachable material can be delivered through nonprofessional people.

Substantial interest, we believe, needs to be based on targeting other family members as recipients of information and advice and training. Again, minority persons should be substantially represented in the cadre of professional or lay manpower at all levels.

The logistical and manpower considerations that we suggest are these: That as has already been stated, the relatively few schools of public health in the Nation are often so far removed, or at least in some instances, from the masses of the elderly, especially the rural elderly, that it could be expected to be quite expensive in travel and man hours to provide sufficient on-site training and health education directly through these resources alone.

Now, in many instances this may not be a big problem, but we think in some instances it will be a major problem.

So far as the role of higher education, we suggest that institutions of higher education with viable components for the delivery of public health expertise be identified for the primary purposes, and I'd like to emphasize this, so far as our perspective is concerned, for the primary purposes of providing consultation and technical assistance to local agencies for purposes of designing educational and service programs tailored to the needs of selected demonstration communities. While we believe that some upper-echelon, some skeletal outline might be devised, we suspect that the actual refinement of the curriculum should have to happen at the local level to meet local needs, based upon the realities of the local situation, to collaborate with local agencies, to conduct needed research, and to design methods to evaluate program outcomes. Again, there very well may be some skeletal design at some operational level, but I think it then has to be suited and fitted to the local situation.

Another role of higher education should be to upgrade course content to more adequately include practical information and community experiences in the field of aging, and to identify both undergraduate and graduate majors and in appropriate health fields to engage in the work of the selected community demonstration project.

We feel that for it to be manageable at the outset you do have to limit yourself to a number of demonstration projects. Now, what we do not see, and we are, I think, of a contrary mind at this point; what we do not see as a role of higher education, is to even attempt to be the primary manpower for on-site health education in any community. Rather, we see higher education people involved in the consultation, technical assistance to the consultation to the communities to help them work out the plans, the nitty gritty of how to, simply because they are there already, and it's sort of a major incidental, but budgets as they are, it's a major accomplishment simply for us to get from Greenville to here, and I'm sure I'll have some accounting to do when I get back.

To accommodate the manpower and the logistical considerations at the community level we suggest the following, and again we make these suggestions at considerable hazard, and we almost duck to keep from getting hit by whatever may come from the audience,

but we suggest consideration of distribution of funds from the Federal level to the Secretary of the Department of Human Resources within the States; grants or contracts from the Department of Human Resources to qualified institutions of higher education to carry out the roles described; grants or contracts from the Department of Human Resources to local public health departments to provide the primary focus, and the primary responsibility for health education training and community organization activities, with consultation and technical assistance from higher education, and with input from other appropriate local agencies. This latter suggestion is based on the traditional role of the local public health department as the primary official agency for promoting and protecting the health of the community. Further, many health departments already have professional health education components, and an interdisciplinary staff capable of contributing to both education and clinical health services for the elderly.

I'd like to pause here just a moment to state that the traditional role of the public health educator has not been one to be one who knows everything and can teach everything. Rather, it has been the role of identifying needs and identifying resources and serving largely in a managerial or catalytic fashion to pull these things together, and again, we would emphasize that just as we do not want to see a high level of dependence on higher education, we do not want to see communities and other agencies to be completely dependent on any one agency within the community. However, as you have said, somebody has to manage, and at the community level we are biased somewhat in the notion that public health is probably best situated to manage that.

Chairman PERKINS. To make it clear here, from the standpoint of administration, a lot of the States have different setups. The Departments of Human Resources in most of the States have now named the agency that administers these programs out of the Department of Human Resources, just like we have in Washington. But do you think they should, in conjunction with, say, the Department of Human Resources, the local departments of health or some other local governmental unit, or just give the Department of Human Resources sole authority along that line?

Mr. BYRD. Well, I think that the Department of Human Resources, and incidentally, I haven't had an occasion to talk to Dr. Morrow for at least a year, so she hasn't influenced my statement at all, but I think the Department of Human Resources is substantially aware of the capabilities of various institutions of higher education in this State, including Duke, I might add, and I think the Department of Human Resources is very much aware of the various capabilities of local health departments, and as has been said sometime earlier today, the quality of leadership, the quality of programming, et cetera, at the local level does vary. It varies because of many things, so the Department of Human Resources, in my opinion, is better situated to make some of these judgments than perhaps any other entity in the State.

Chairman PERKINS. Thank you.

Mr. BYRD. To comment just briefly on our school, which is not a school of public health, the School of Allied Health and Social Work at East Carolina houses, among other things, the first bacca-

laureate program in community health education ever approved by the Society for Public Health Education.

Also, having recognized the importance of substance abuse, we established an alcoholism program 11 years ago, which has made a significant contribution to developing and staffing many of the community service programs in North Carolina.

In addition, in our particular case, we have a graduate level concentration called a Master of Public Administration, and we have in the school also a department of environmental health with both undergraduate and graduate degrees, and from my perspective, many of the skills of that department are relevant as very important resources to the environmental aspects of residential safety and rural life.

And I might add, gentlemen, that in our health education programs, all students are required to take community based internships for credit, and we have working relationships in agency settings in community settings, mostly in eastern North Carolina, 50-plus situations where without any significant effort, other than a few telephone calls, we have the opportunity to send a student to that place.

A major problem that I see, I think is that at this moment in time budgets are so tight that we absolutely do not have the capability, in terms of transportation and those kinds of related expenses, of doing the job even with our present community internships that we would like to do. We're very much strapped. I would add also that at the local health department level, those that have health educators are using those people very substantially in realms where there are already mandated programs or categorical funds, and a health director, no matter how interested he may be in the problems of the aged, is stuck with the problem that if his health educator is, in fact, paid to do family planning in family planning clinics, then he certainly is not at liberty to pull that person away from that job. He does not have the latitude to pull that person out and redeploy that person into another area.

I think we do have to anticipate some expenditure of money out of the local level, and from my perspective, I would be inclined to spend at least $3 at the community level for every $1 at the level of higher education. I haven't checked this out with the Chancellor, but I think he would go along with that.

Thank you very much.

Mr. ANDREWS. Well, I'm just amazed that on such short notice you've been able to share a lot of very valuable information and opinions with us. We're very appreciative, and look forward to seeing if you can do better with more time.

Mr. BYRD. Thank you.

Mr. ANDREWS. Dr. Ensley, would you care to add or supplement anything? Are you the one who is the author of the book?

STATEMENT OF DR. DONALD ENSLEY, ASSOCIATE PROFESSOR, SCHOOL OF ALLIED HEALTH AND SOCIAL WORK, EAST CAROLINA UNIVERSITY

Dr. ENSLEY. I'm afraid not, sir. You are thinking of Dr. Register, who has done some extensive research in this particular area, and we are sorry that he's not here today.

I would just like to say to both of you, as well as the other staff members, that we are happy to be here, and we wanted to bring a certain aspect and element of the particular rurality, of rural North Carolina, some of the things that we felt would possibly be missed in the bill, and that was what one of our purposes was. The other purpose was to talk about something that I mentioned to my colleague, Dr. Rose, as something that I have heard throughout the day. And that's again the interdisciplinary approach to such a problem. And last, I think, without being redundant, everything I have heard today basically supports some of the things that we attempted to get at in our presentation. So we are looking forward to working with you and anyone else on this monumental task.

One thing I would like to say in closing is that I'm really excited about this. I almost want to call you Alvin Toffler from looking at this from a futuristic point of view. The time is right, and we are geared up and ready to go, and by the way—I did speak to Congressman Jones on this, and he seemed to be a little excited, a little bit jealous about the fact that you got the jump on him.

Thank you.

Mr. ANDREWS. We will welcome Congressman Jones aboard at any time or place. He is a great and good friend.

Chairman PERKINS. Thank you, gentlemen. I have enjoyed your testimony very much.

Mr. ANDREWS. Mr. James Allen, from the UNC School of Public Health.

[Prepared statement of Dr. James Allen follows:]

PREPARED STATEMENT OF JAMES E. ALLEN, PH.D., MSPH, ASSOCIATE PROFESSOR, HEALTH POLICY AND ADMINISTRATION, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

Mr. Chairman: I applaud your effort to help older Americans learn to help themselves by becoming more educated about what their needs are and what they can do to help themselves. That is what health education is all about: first, helping people understand what their health needs are and then, secondly and equally importantly, helping them become active in meeting their own health needs. In the attached I have tried to provide a simple brief overview of what a useful senior citizen center health education curriculum might look like and who could teach it. I have tried to keep it simple. It is organized considering both priority of need and in a sequence that might attract and interest the average older citizen.

In my opinion the most elementary educational needs are not now being met, hence the topics are focused on the most immediate needs each older person is likely to have.

Subsequent courses might deal with such equally germain issues as adequate housing and budgeting, which also have impacts on health status.

PROPOSED CURRICULUM AND TEACHING RESOURCES FOR HR 4472

BASIC KNOWLEDGE AREAS	BASIC PRINTED INFORMATION NEEDS	BASIC BEHAVIORAL GOALS	LENGTH AND TEACHING RESOURCES
1. MEDICINE Understanding the necessity and importance of each individual older American taking agressive steps to have both their pharmacist and physician review with them both their prescription and non-prescription medicines for both side effects and possible adverse interactions.	Sample materials like circulars that come with medicines describing side effects and interactions Examples of the most common interactions older persons encounter	--to become an informed pro-active participant in "managing" ones own medication program by beginning to recognize when one is experiencing a drug reaction. --to become aware that older persons may react differently to drug in both combinations used and dosages given	2 sessions 1½ hours each Teachers: local pharmacists experienced in geriatric drug care, public health faculty and physicians
2. NUTRITION Understanding basic nutritional needs of older persons	Simplified guides to what an adequate diet is for older persons	To be able to form ones own opinion about how adequate ones own diet is and improve ones eating habits	2 sessions 1½ hours each Teachers: nutritionists in local nursing homes and hospitals and schools of health
3. SERVICES AVAILABLE Understanding the continuum of care and programs available locally from minimum assistance in the home to in-patient care in a nursing home	Simplified versions of Older Americans Act All of the services available through the Area Agency on Aging Social Security Act Medicare A, B Supplemental Security Insurance (Federal and state and local sharing arrangements) Other services and programs e.g. Meals on Wheels Food Stamps Senior Citizens discounts Consumer and Patient RIGHTS the OMBUDSMAN PROGRAM ETC.	Practice in actually accessing services available through the several acts and programs available - through role playing and actual visits -be introduced to leaders of local activists groups such as American Association of Retired Persons Older Womens League Gray Panthers	3 sessions 1½ hours each Teachers: local service providers and Schools of Public Health Faculty, local public health and social services personnel, Area Agency on Aging Staff

BASIC KNOWLEDGE AREAS	BASIC PRINTED INFORMATION NEEDS	BASIC BEHAVIORAL GOALS	LENGTH AND TEACHING RESOURCES
4. GROWING OLD TOGETHER The aging process - how it manifests itself physiologically and psychologically	Factual information about The aging process - it's physiological and psychological symptoms and practical guidance on how to cope with them	-learning to predict what will happen to them as they age -to learn they are not alone in experiencing the physical and psychological manifestations of the aging process -providing the chance to compare and discuss their own experiences in the aging process thus making growing old less scarey and more shared	4 sessions 1½ hours each Teachers: local community college faculty, local nursing activity directors, public health faculty, local health department health educators, Area Agency on Aging staff
5. DEFENDING YOURSELF AGAINST THE "BUREAUCRACY"	Knowledge of the concept of case management and knowledge of the scales used for measuring activities of daily living capacities used by physicians, social and intake workers to "diagnose" or place the individual older person	to be able to self-diagnose one's own capacity for performing the activities of daily living hence develop ones own judgement about the "APPROPRIATENESS" of the recommendations made by physicians service workers and others about what services you need and where you "PLACE" on the scale of activities of daily living Goal: to pro-actively understand what "case management" is and participate as an active partner in managing one's "case"	2 sessions 1½ hours each Teachers: case workers from local health and social services departments, area agency on Aging staff, public health faculty, local college faculty

James E. Allen, Ph.D., MSPH
Associate Professor Health Policy and Administration
School of Public Health
University of North Carolina at Chapel Hill

December 20, 1983

STATEMENT OF JAMES ALLEN, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

Mr. ALLEN. At the risk of being one who is like the fool rushing in where angels fear to tread, I took the liberty, when Dean Ibrahim asked me to write some basic thoughts concerning this bill, to do what you might call a feasibility check.

If I were a senior citizen in a local community, what would it be that I might want to go and experience in such a health education program? So on the second and third page I have outlined what seemed to me to be possible courses, and the teaching sources within the communities for persons who basically need health education regarding being an older person. The five areas are, the medicines that they take, which have been mentioned numerous times today; their nutrition; the services available to them; growing old together; and what I have lastly called defending yourself against the bureaucracy.

Essentially, I think there is no great need for a lot more printed information than is already in existence. That is to say, if you are teaching about medicines there are circulars available, simple examples can be given by pharmacists and others in a teaching situation.

Fortunately for me, with Dr. Capowski sitting on my right here, the first teachers that I list are local pharmacists, experienced in geriatric drug care.

We also have plenty of persons available to teach nutrition; nutritionists in local nursing homes, hospitals, schools of public health, they already exist out there all across the United States.

What people who are older need to be able to do is to form some judgement about the adequacy of the food they are getting each day, whether they are in their homes or in a nursing home.

The third area that I envisioned as being very valuable and needed is what you may call services available. Few senior citizens really understand the breadth of services that are available to them, and I think some small pamphlets, maybe augmenting what already exists, may be done up which would allow older persons to really understand more realistically what is out there already in the community for them.

The fourth area is simple information to these people about what the aging process is, and how it manifests itself physiologically and psychologically so that they can predict what's going to happen to them. They can understand that they are not alone and have discussion groups for that.

The fifth area that I think a curriculum might address is defending yourself against the bureaucracy in the sense that——

Chairman PERKINS. Let me interrupt you and compliment you. You've been here so diligently all day, and natually we're all pleased to hear you.

I want to state that this has been a very fruitful day from my viewpoint. I think that the testimony of all of the witnesses has been very helpful to the committee, and all the witnesses have made a great contribution to a piece of legislation that I feel will become law, and I think we all feel that Congressman Andrews has done a great thing for not only his congressional district, but also

for the country in introducing the legislation, and we'll do our best to make sure it becomes law. Thank you.

Mr. ANDREWS. Thank you again, Mr. Chairman.

Mr. ALLEN. The fifth and final point that I want to make is that I think that we would try to have behavioral goals for all of these learning areas, in terms of aiming at the older person's taking more charge of the decisions that are made that affect them that more typically they seem to leave to the health professions. So I think it would be very valuable for a program like this to have an understanding, to help them understand that there is this case management concept in that, in fact, they are considered a case, and there is a case worker trying to help them manage their old age, and if there is not a case worker helping them manage their old age, then they may properly ask for this assistance. So I think that in essence older persons simply need to be enabled, through more information, to take more charge and more control over their own lives.

And the teachers are there. I think all that really is necessary is a program that would mobilize these knowledge areas among large groups of persons who already have it to present it to the older persons. Thank you.

Mr. ANDREWS. It's rather amazing to me to see your ultimate recommendations so much parallel each other. I've learned a lot from that, if nothing else here today.

Now, some of these suggestions I've heard here today would, I fear, involve a lot more cost. Certainly, a big part of what I am attempting to stay with, as much as feasible, is the concept of using graduate students under the supervision of faculty. That was largely because I thought it would accomplish two things. One was that this program not only benefit senior citizens immediately from what was to be done, but that it serve as a laboratory whereby this program affords the institutions of higher learning an opportunity to improve upon their teaching techniques.

When you say to let it be done substantially by some existing entity outside the institution of public education, you're missing that objective, which isn't to say it shouldn't be done, but I'd just say that that would mitigate, in my view, somewhat away from what I intended. But they may be done in conjunction with each other by some sort of partnership arrangement.

The other thing that I would reemphasize is cost. People in the county or State or wherever, existing offices outside the institution of public education that have been referred to, or apparently envisioned, are people who are necessarily working for a living. When we work, we expect to be paid whatever our credentials warrant. Most of us think we're paid too little already If the individuals envisioned are going to spend 20 hours a month, or whatever it may be, performing this sort of task, they are going to expect to be paid at the going rate.

The same would be true if you brought in representatives of practicing professional people, health care delivery people, such as psychiatrists, that have approached us and would like to be involved with this bill. That's not what I m looking for. I don't think the Congress would pass it in the first place. I don't think the Con-

gress is looking today for another highly expensive program to address anything, no matter how serious be the consequence.

Now, certainly we are not here to exclude any offer. We certainly need help. But I would reemphasize that the cost of the program is, in my view at least, a very very high priority. Hence my initial thought, would be not stray too far away from people who might be willing to, or if not willing, induced to serve in those capacities without anything approaching normal or professional private wage or fee, or contract.

Hence, I will have a strong propensity to stick, certainly not totally, but more or less as much as possible, to the institutions of higher education who will use students with faculty assistance and supervision, primarily only that, and through course credit and otherwise, and through some payment, yes, through work study programs and reimbursement for mileage or a meal eaten on the road; but certainly not a per hour or per diem going rate reimbursement.

Another thing is that I would emphasize that to me the objective is far more than to dispense information. We can do that through the mails. We can develop a pamphlet, and we have the names and addresses of all of the various organizations and associations, and we can mail everybody some pamphlets. That's not what I envision at all. Certainly, we need to start with information, but I think we will accomplish so much by getting these people involved in peer groups, by getting people who are elderly together and identifying those with hypertension or who are perhaps overly dependent upon drugs, or who have the implanted hips, or whatever, and showing them that they have something in common with each other. Not only might they get out of their loneliness but also their fears arising from the peculiarities of their difficulty. Before, they were relatively isolated with that. I think to get with others who have similar problems and fears and so forth, and to hear good instruction on how to live with what they have, to make progress together, I think, is the main objective, or a big part of what I have in mind. Dissemination of information is not what I'm attempting to address, although that's part of it. I hope we can go much, much further and cause a lot of people of competence to be out here to induce, to bring them together, to follow through, to evaluate, to make a great program without having to pay those people the normal fees for furnishing that great and much needed kind of service. So I hope, then, that we can stick somewhat to the concept of using the senior citizens centers with other places that might be voluntarily made available. Many, many people go to these centers, people of similar age and so forth. For the most part those centers basically serve the poor and the needy in the various communities in which they are situated.

Ms. JOHNSON. Especially if you include the nutrition centers that are getting closer and closer to being senior citizens centers.

Mr. ANDREWS. Right, and I think that's good. They are the ones who perhaps lack the information. Two or three elderly people have spoken to me on the streets, they have seen some publicity about the legislation, and they have spoken to me in opposition to it. And one of the ladies had on—I could hardly watch her while she talked—she had on one of the most beautiful diamonds I have

ever seen. I could hardly see her eyes as she talked, but she was saying that you can't teach an old dog new tricks, and that older people already had more information than they were going to respond to, et cetera, et cetera.

Granted, many older Americans don't need this program. Many older Americans do procure, through the psychiatrists or whatever, whatever information and assistance they want, and they don't want any more. That's all well and good. That's fine. I'm glad they're able to do that. But there are so many who aren't, and so I guess I have a propensity to continue to address the program not exclusive to, but primarily to those people, and that is essentially what you find in these senior citizens centers.

But anyway, I'm not at all unwilling, and in fact I am desirous of considering all of the offers of information or of assistance, but please excuse me if I act a little bit rigid in not getting too far afield in cost.

Are there any further statements to be made?

FROM THE AUDIENCE. Are we to assume that the record will be kept open for additional statements?

Mr. ANDREWS. Yes; from at least those present. Now, you can't make a hearing record available just, you know, for any mailing, but for those who are certainly present here you are, in effect, to an extent, a witness by your presence, and I believe, as Mr. Dean has kindly pointed out, the maximum period of time that is permitted by the rules is 30 days. So it can't be kept open beyond that, but if any of you who are physically present during this hearing wish to submit something for the record, without objection, we'll be happy to receive it for the record.

Is there anything else?

Ms. HARRIS. Yes; I'd like to read a very short statement.

Mr. ANDREWS. Would you like to come around? As in the case of this lady, if you submit a statement we'll need to get for the record in each instance name, address and et cetera, who you represent, if anyone, and so forth. That should accompany any statement that is submitted. Thank you.

STATEMENT OF LORNA HARRIS, ASSISTANT PROFESSOR, SCHOOL OF NURSING, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, ON BEHALF OF DEAN LAUREL COPP, SCHOOL OF NURSING

Ms. HARRIS. Gentlemen, my name is Lorna Harris, and I am an assistant professor in the School of Nursing, University of North Carolina, Chapel Hill. I have a letter I'd like to read to you from Dean Laurel Copp of the school of nursing.

Mr. ANDREWS. Fine.

Ms. HARRIS. We support your proposed legislation in H.R. 4472, which would enhance the quality of life for older Americans. May we ask you to consider expanding section 704(b)(1) to include also schools of nursing.

We believe we have demonstrated effectiveness in precisely the care your bill describes, and would like to share our faculty planned student experiences in the school of nursing.

The students have worked for 4 years with the senior citizens nutrition sites in the Chapel Hill-Carrboro area. Programs have been presented by senior baccealaureat nursing students which enhance physical and mental health of the participants.

Since 1979 student nurses have been assigned to the Orange County Health Department as part of their primary care nursing experience. These centers are considered part of the county health department's responsibility. In the past, students have provided health maintenance programs and illness prevention programs. They've held screening sessions on colon rectal cancer, glucose, and protein in the urine, and monitored the elderly for elevated blood pressures. Senior citizens were counseled individually regarding their therapeutic diets, they were counseled on their medications and the actions of their medications, and were referred to their physicians or to a health care agency when needed.

Student nurses and nurse faculty make home visits to those persons who are considered homebound or ill. These home visits made by young nursing students to elderly frail citizens have resulted in several referrals to social and health agencies, because student and faculty in our school of nursing have a demonstrated record of success.

For these reasons we urge you to include schools of nursing in your proposed legislation. We believe we can continue to be of service and meet many of the goals for the elderly you and we share.

Mr. ANDREWS. Very good, thank you very much, and please thank the Dean for me.

[Prepared statement of Dean Laurel Archer Copp follows:]

PREPARED STATEMENT OF DEAN LAUREL ARCHER COPP, SCHOOL OF NURSING, THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

We support your proposed legislation in H.R. 4472 which will enhance the quality of life for older Americans.

May we ask you consider expanding Sec. 704 (B-1) to also include Schools of Nursing. We believe we have demonstrated effectiveness in precisely the care you describe and would like to share our faculty planned student experiences in the School of Nursing during the past 4 years, in the senior citizen centers located in the Chapel Hill-Carrboro area. More details can be obtained from me or Mrs. Lorna Harris, Nurse Faculty Member, U.N.C. School of Nursing.

Programs have been presented by senior baccalaureate nursing students which have enhanced physical and mental health of participants in the Golden Ages Happy Circle located at the Chapel Hill-Carrboro Multipurpose Center and the Meet Your Neighbor Club located at Carr Mill Mall. Since 1979 student nurses have been assigned to the Orange County Health Department as part of their primary care nursing clinical experience. These centers are part of the Co. health department's responsibility.

In the past students have provided health maintenance and illness prevention programs, have held screening sessions for occult blood in the stool, glucose and protein in the urine, and monitored the elderly for elevated blood pressure. Senior citizens were counseled individually regarding their therapeutic diets. When on medication, students explained the action of their medication and if needed referred any patients with suspected side effects to the physician or the health care agency.

Student nurses and nurse faculty made home visits to those club members who have been reported homebound and/or ill. These home visits made by a young student nurse to an elderly frail citizen have resulted in several referrals to social and health care agencies because of problems identified in the club member's home.

Because students and faculty in our school of nursing have a documented record of success with one aspect of care for the elderly you advocated in your news release (late Nov. 1983) and have included in H.R. 4472 we urge you to include Schools of Nursing in your proposed legislation. We believe we can continue to be of service and meet many goals for the elderly you and we share.

Mr. ANDREWS. Yes; I had envisioned all along that the schools of public health might be in the front line, but surely schools within the institutions of higher education in the field of medicine at whatever aspect, and teaching and social work and others, are very, very apt schools, and could furnish, no doubt, people of tremendous quality and willingness to assist. I envision that that would be not only granted, but encouraged. Thank you again.

Are there others who would add a final touch? If not, we just thank you again. I think it's been a great day, and may I say again—and I don't need to say this to be polite because he has left—but let me just say generally that chairman Carl Perkins is some kind of person. He is disarming; he has a mannerism and a speech and use of grammar, and so forth, that is very, very much disarming. He's a brilliant person. He probably carries as much weight for the poor, for education, for health, and for many other things; more, I would say probably, than any Member of the Congress. I would expect people on both sides of the aisle of whatever persuasion, many of whom vote against much of what he proposes, never the less recognize that he is a dynamo. He's hard to beat. He's virtually unstoppable in energy, dedication, and ability. I'm just so thankful that if we get this through our subcommittee we'll have, eventually after hearings and deliberations, what's called a markup. Whatever bill we report out, if we do, goes to his full committee. We've worked on a lot of bills having to do with older Americans and other matters, and, without exception, the chairman every time picks it up and goes with it. He let's me handle it, but he's totally supportive; and you know, when you get to the floor many of the chairmen will take the bill that the subcommittee chairman has done all that work on, sometimes for years to ever get it to the floor, and then the chairman of the committee, as he or she has every right to do, will just assume to manage the bill, and the subcommittee chairman will sit back there and have relatively little to do with it. Chairman Perkins is not that way at all. If this goes to the floor, I can assure you he will urge me to be manager of it, and he will be probably the first speaker to support and he'll get up there and just explode that House, and then he'll sit down and be of whatever assistance he can.

I look forward to it very much. I don't intend to let my enthusiasm be dampened by the fact that I well know, of course, that there will be some dissent, and some, you know, at times even a little anger or animosity or whatever, but in our subcommittee it will not be partisan; it will not be based just on geography or on Democrat or Republican concerns, or whatever. We have excellent staff on both sides of the aisle—well motivated—and I know that the objectives of all of us will be essentially the same.

Thank you again for your presence and your support.

[Whereupon, at 3:15 p.m., the hearing was adjourned.]

37-680 O—84——8

OLDER AMERICANS HEALTH EDUCATION AND TRAINING ACT

WEDNESDAY, MARCH 28, 1984

HOUSE OF REPRESENTATIVES,
COMMITTEE ON EDUCATION AND LABOR,
SUBCOMMITTEE ON HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:30 a.m., in room 2261, Rayburn House Office Building, Hon. Ike Andrews (chairman of the subcommittee) presiding.

Members present: Representatives Andrews, Petri, and Chandler.

Staff present: Gordon A. Raley, staff director; Gertrude L. Wright, senior legislative associate; Deborah L. Hall, clerk; and Edward Larson, Republican assistant counsel for Human Resources.

Mr. PETRI. We will begin this hearing, which is on H.R. 4472, the Older Americans Personal Welfare Education and Training Act.

Chairman Ike Andrews regrets that he cannot be here at this particular time. His mother took suddenly ill and he has had to attend to that family responsibility.

He does have a statement in support of this legislation that I would like to enter in the record at this point.

[Opening statement of Chairman Andrews follows:]

OPENING STATEMENT OF HON. IKE ANDREWS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH CAROLINA AND CHAIRMAN, SUBCOMMITTEE ON HUMAN RESOURCES

We are meeting today to discuss H.R. 4472, a bill to amend the Older Americans Act of 1965 by adding a new title relating to multipurpose senior centers health education and training.

I am joined in sponsoring this bill by Congressman Perkins, Chairman of the Education and Labor Committee, and by a number of my colleagues, including Mr. Pepper, Mr. Roybal, and Mr. Biaggi.

This bill is the result of years of working with the problem of how to meet the health care needs of our nation's 25 million elderly, and at the same time, help check the rapidly escalating cost of providing that care to them.

Health care costs are a particularly acute problem for older Americans. The federal government, through Medicare and Medicaid, pays close to $100 billion per year, and that is only 70 percent of the tab. The rest comes from the pockets of the elderly themselves, and it is money they can frequently ill-afford.

Not all of this money is well spent, nor would all of it be necessary if older Americans had access to better information and motivation on such questions as over-the-counter drugs, self-care, and health promotion generally. The 1981 White House Conference on Aging recommended greater emphasis on "promotion and maintenance of wellness," and that is what this bill is all about.

One of the pieces of legislation under the Subcommittee's jurisdiction is the Older Americans Act, and I have come to believe that part of the answer to health care needs and costs can be found in the structure presently existing under that Act.

For any education program, we need a curriculum, teachers, classrooms, and students. For the purpose of health education and training for older Americans, I believe these things are already available. They simply need to be brought together.

For students, we have the 25 million older Americans of this country, and 9 million of these are already involved with Older Americans Act programs. For classrooms, we have the national network of multipurpose senior centers, already provided for in the Older Americans Act. For curriculum, we have the work already done by public health and community health education professionals. For teachers, we have the faculty and students of a wide array of institutions of higher education specializing in public health, the medical sciences, education, and gerontology.

This morning we will be hearing from representatives of these different groups. Our first witness is David Affeldt, representing the American Association of Retired Persons. I believe this is the largest of the organizations representing older Americans, and we look forward to hearing his comments on H.R. 4472.

Mr. PETRI. Our first witness is David Affeldt. He is the legislative consultant from the American Association of Retired Persons, headquartered here in Washington.

Welcome. We look forward to placing your statement in the record, and you may proceed as you wish.

[Prepared statement of David Affeldt follows:]

PREPARED STATEMENT OF DAVID AFFELDT, LEGISLATIVE CONSULTANT, AMERICAN ASSOCIATION OF RETIRED PERSONS

Congressman Andrews and Members of the Human Resources Subcommittee, the American Association of Retired Persons welcomes the opportunity to appear at this hearing on H.R. 4472, the Older Americans Health Education and Training Act. At the outset, we wish to express our support for this bill which is designed to promote health education and training for older Americans, as well as disease prevention. AARP strongly supports both objectives. We have already initiated activities to implement these goals, which I shall cover briefly later.

The Association also wishes to emphasize that good health for older Americans involves several diverse and complex issues, including soaring health care costs, quality care, the heavy emphasis on institutionalization, and others. The proposed Older Americans Health Education and Training program represents one aspect—an important one I might add—for developing a coordinated and effective response for making the later years as healthful and fulfilling as possible.

A. NEED FOR HEALTH EDUCATION AND TRAINING

The bill fully recognizes that diseases affecting elderly persons are changing, as are the most effective remedies to combat these infirmities. Infectious diseases, such as pneumonia and tuberculosis, were major causes of disability and death during the earlier stages of our health care delivery system. Consequently, we built a system designed primarily for the treatment and care of acute, episodic illnesses.

However, the pattern of illness has changed today. Chronic health impairments are now the primary causes of disability and death.

This is significant because the cure for acute conditions is primarily within the bailiwick of the medical care system. Chronic conditions, though, typically, are not responsive to short-term acute intervention, but are usually influenced more by personal living habits.

Experts are increasingly concluding that personal lifestyle is the major factor influencing disease today, contributing 50–55 percent to the risk of chronic diseases. Other major factors affecting illness include the environment, which may contribute about 25 percent, and genetics, perhaps 10 to 15 percent.

We firmly believe, as I am sure you do, that effective health promotion should be given greater emphasis in preventing, or at least postponing the onset of disease. There is already compelling evidence to demonstrate beyond any reasonable doubt that this is an effective approach. For example, there has been a 2 percent reduction per year in deaths from heart disease. A greater emphasis on health promotion and basic changes in lifestyle have contributed to this development, including changes in American smoking, eating and exercise patterns and a national effort to treat persons with high blood pressure.

B. AARP'S HEALTH PROMOTION PROGRAM FOR OLDER ADULTS

AARP has long recognized the importance of preventive health care. One example is the new Health Promotion and Education Program for Older Adults begun by AARP in 1984. This program is designed to reach one million persons aged 50 or older in 1984 by increasing their awareness of health risks, preventive measures, health care alternatives and the normal aging process. AARP is conducting this program jointly with the National Health Screening Council for Volunteer Organizations.

AARP's Health Promotion & Education Program is designed to direct the elderly's attention each month to a particular ailment or disease. For example, the focus was on the heart and cardiovascular system for the month of February. Later this year, the focus will be on mental health for May, diabetes for June and arthritis for September.

Older Americans will have an opportunity to meet and talk with health care professionals, view films on featured topics, watch demonstrations on the latest medical technology, receive free health screening, and take part in group discussions at more than 600 locations throughout the county—hospitals, senior centers, nutrition projects housing complexes an college campuses.

C. BENEFITS TO OLDER AMERICANS

These activities will make aged and aging persons more aware of disease warning signals as well as appropriate lifestyles and eating habits to promote and maintain good health. Your bill, Congressman Andrews, can help to build upon these present efforts and to expand the concept of health education and training.

It can lead to a longer period of good health. This, in turn, can contribute to more productive years for those older persons who want to remain active and vigorous.

These are obviously very important dividends for our nation and the elderly. Your bill, Mr. Chairman, and the AARP Health Promotion Program for Older Adults can be a cost effective means to promote a healthier older age.

D. INVOLVEMENT OF PRIVATE, NONPROFIT ORGANIZATIONS

H.R. 4472 would basically utilize schools of public health in conjunction with multipurpose senior centers to develop and implement health education and training programs for persons 60 or older. Both institutions are well equipped to play a prominent role in launching and operating these programs. Schools of public health have the faculty, the curricula and the facilities. Multipurpose senior centers provide a wide range of services to serve large number of older Americans.

However, AARP believes that private, nonprofit organizations should also be encourage to promote health education and training. AARP, for example, has more than 16 million members. We have the capacity to reach literally millions of older persons to educate them about health problems and effective ways to promote good health. Through its Health Advocacy Services program, AARP seeks to promote good health practices among older adults and encourage effective use of the health care system. A variety of educational materials and volunteer services are available to assist older adults in becoming wise health consumers and informed participants in the health care systems affecting their lives. We, as well as other organizations, can work cooperatively or in conjunction with Schools of Public Health and senior centers to provide health promotion services in the community. AARP has the ability and resources to assist with this training and education program, which will give it a broader and more effective base.

For these reasons, we urge that the bill should clarify that nonprofit organizations are eligible to participate in this program.

E. CONCLUSION

In conclusion, we support enactment of H.R. 4472. The Older Americans Health Education and Training Act can be an important step to make the later years healthier. One only suggestion for improvement is to broaden the base to include private nonprofit organizations as well as schools of public health. Accordingly, we urge that this addition be included in the bill.

STATEMENT OF DAVID AFFELDT, LEGISLATIVE CONSULTANT, AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY ROBIN MOCKENHAUPT

Mr. AFFELDT. Thank you very much, Congressman Petri.

The American Association of Retired Persons welcomes the opportunity to appear at this hearing on H.R. 4472, the Older Americans Health Education and Training Act.

At the outset, we wish to express our support for this bill which is designed to promote health education and training for older Americans as well as disease prevention. AARP strongly supports both objectives. We have already initiated activities to implement these goals, which I shall cover briefly later.

The association also wishes to emphasize that good health for older Americans involves several diverse and complex issues, including soaring health care costs, quality care, the heavy emphasis on institutionalization and others. The proposed Older Americans Health Education and Training Program represents one aspect—an important one, I might add—for developing a coordinated and effective response for making the later years as healthful and fulfilling as possible.

The bill fully recognizes that diseases affecting elderly persons are changing, as are the most effective remedies to combat these infirmities. Infectious diseases, such as pneumonia and tuberculosis, were major causes of disability and death during the earlier stages of our health care delivery system. Consequently, we built a system designed primarily for the treatment and care of acute, episodic illnesses.

However, the pattern of illness has changed today. Chronic health impairments are now the primary causes of disability and death.

This is significant because the cure for acute conditions is primarily within the bailiwick of the medical care system. Chronic conditions, though, typically, are not responsive to short-term acute intervention but are usually influenced more by personal living habits.

Experts are increasingly concluding that personal lifestyle is the major factor influencing disease today, contributing 50 to 55 percent to the risk of chronic diseases. Other major factors affecting illness include the environment, which may contribute about 25 percent, and genetics, perhaps 10 to 15 percent.

AARP has long recognized the importance of preventive health care. One example is the new Health Promotion and Education Program for Older Adults begun by AARP in 1984. This program is designed to reach 1 million persons aged 50 or older in 1984 by increasing their awareness of health risks, preventive measures, health care alternatives and the normal aging process. AARP is conducting this program jointly with the National Health Screening Council for Volunteer Organizations.

AARP's Health Promotion and Education Program is designed to direct the elderly's attention each month to a particular ailment or disease. For example, the focus was on the heart and cardiovascular system for the month of February. Later this year, the focus

will be on mental health for May, diabetes for June and arthritis for September.

These activities will make aged and aging persons more aware of disease warning signals as well as appropriate lifestyles and eating habits to promote and maintain good health. H.R. 4472 can help to build upon these present efforts and to expand the concept of health education and training.

It can lead to a longer period of good health. This, in turn, can contribute to more productive years for those older persons who want to remain active and vigorous.

These are obviously very important dividends for our Nation and the elderly. Your bill and the AARP Health Promotion Program for Older Adults can be a cost-effective means to promote a healthier older age.

H.R. 4472 would basically utilize schools of public health in conjunction with multipurpose senior centers to develop and implement health education and training programs for persons 60 or older. Both institutions are well equipped to play a prominent role in launching and operating these programs. Schools of public health have the faculty, the curricula and the facilities. Multipurpose senior centers provide a wide range of services to serve large numbers of older Americans.

However, AARP believes that private, nonprofit organizations should also be encouraged to promote health education and training. AARP, for example, has more than 16 million members. We clearly have the capacity to reach literally millions of older persons to educate them about health problems and effective ways to promote good health. Through its Health Advocacy Services Program, AARP seeks to promote good health practices among older adults and encourage effective use of the health care system.

A variety of educational materials and volunteer services are available to assist older adults in becoming wise health consumers and informed participants in the health care systems affecting their lives. We, as well as other organizations, can work cooperatively or in conjunction with schools of public health and senior centers to provide health promotion services in the community. AARP has the ability and resources to assist with this training and education program, which will give it a broader and we believe more effective base.

For these reasons, we urge that the bill should clarify that nonprofit organizations are eligible to participate in this program.

In conclusion, we strongly support enactment of H.R. 4472. The Older Americans Health Education and Training Act can be an important step to make the later years healthier. Our only suggestion for improvement is to broaden the base to include private nonprofit organizations as well as schools of public health. Accordingly, we urge that this addition be included in the bill.

That concludes our testimony.

I would like to introduce Robin Mockenhaupt. Robin is very knowledgeable about the Health Promotion Program and she would be available to respond to questions that you may have about the way the program operates.

Mr. RALEY. First of all, let me thank you very much, Dave, for the fine presentation. I did talk with Chairman Andrews a few mo-

ments before coming in and he will be joining us I hope in a few moments. His mother was hospitalized late last night, unexpectedly, so he is looking into that now.

One of the things he is particularly interested in, and I talked a little bit about the testimony you would be presenting, was the sorts of private nonprofit groups that you would anticipate being added or being included beyond just institutions of public health.

Perhaps you could give us some examples.

Ms. MOCKENHAUPT. Currently we are initiating a program with the American Red Cross and have just recently put together a guide for both AARP chapters and units as well as Red Cross chapters, called Working Together for Good Health, which outlines the kinds of activities that chapters can get involved with in health promotion.

That is an example of the kinds of other nonprofit organizations that we currently have contacts with. The American Cancer Society, the Heart Association, many of the voluntary nonprofit organizations that deal with health entities issues we also currently have linkages with, and I feel they would be useful resources also for this kind of training program that is highlighted in the bill.

Mr. AFFELDT. I would also like to add I would think your senior membership organizations would be ideally suited for assuming this role because they would reach out to literally thousands and perhaps millions of senior citizens. Labor unions would be another group that could perhaps be very helpful, and maybe churches, church-based organizations and many others.

Mr. RALEY. On page 3 of the testimony you mentioned there were a number of lectures and various films giving demonstrations, screenings and things like that concerning health promotion. Particularly with regard to various films or other sorts of media, have those been developed by AARP?

Ms. MOCKENHAUPT. They have been developed by AARP in conjunction with our cosponsors for the program, the National Health Screening Council for Voluntary Organizations.

Mr. RALEY. I am presuming if we are able to get some positive action on H.R. 4472 that you will be able to share that with us.

Ms. MOCKENHAUPT. Absolutely, be glad to.

Mr. RALEY. If I might introduce minority counsel, Ed Larson.

Mr. LARSON. I would like to ask one question. You talked about this bill only letting universities participate, of course, and, even beyond that, the bill appears fairly specific about what universities would qualify.

Do you know how many entities in all would be eligible to participate the way the bill is drafted now?

Mr. AFFELDT. Schools of public health.

Mr. LARSON. Do you know how many would be qualified to meet the requirements? The reason I ask the question is that, at an earlier hearing, testimony was received that only 14 entities would qualify and I don't know the basis for that. Do you have any knowledge on that point?

Ms. MOCKENHAUPT. I do, just because I graduated from a school of public health. There are about 21 schools of public health around the country.

Mr. LARSON. Thank you.

Mr. RALEY. Thank you very much. I know Congressman Andrews appreciates it as well.

Mr. AFFELDT. I thank you, too.

Mr. RALEY. Next we will have Mr. Neil Gallagher. He is chairman of the Health Science Department at Towson State University, Towson, MD.

Mr. Gallagher.

[Prepared statement of Dr. Neil Gallagher follows:]

PREPARED STATEMENT OF DR. NEIL GALLAGHER, CHAIRMAN, SCIENCE DEPARTMENT, TOWSON STATE UNIVERSITY, REPRESENTING ASSOCIATION FOR THE ADVANCEMENT OF HEALTH EDUCATION

Chairman Perkins, Chairman Andrews, Distinguished Members of the Human Resources Subcommittee.

My name is Neil Gallagher. I am the chairman of the Health Science Department at Towson State University. I am speaking today as a representative of the Association for the Advancement of Health Education, an individual membership organization composed of health educators charged with the preservation and improvement of health through education. As part of the 35,000 members of the American Alliance for Health, Physical Education, Recreation and Dance, the Association speaks for concerned educators in the area of health education.

Thank you for the opportunity to speak to you today about this very important issue of health education for elderly Americans.

First, I would like to commend you for considering H.R. 4472, the Older Americans Personal Welfare Education and Training Act. Your attention to this bill demonstrates your concern for elderly Americans and your commitment to seek creative solutions to human problems in this era of fiscal responsibility.

As a health educator, I am convinced of the need for health education for people of all ages. Our minds, our bodies, and our health needs change as we move through life's stages. Education is, and should be, a lifetime venture, not terminating with formal schooling in our youth. Lifetime learning about ourselves—health education—is particularly vital to us as we age, for it is during this time that the body undergoes rapid changes which can confuse and tax emotional, physical, and financial resources—at a time when such resources are limited.

As H.R. 4472 points out, while the elderly make up only 11 percent of the population, they consume 29 percent of the total health care expenditures, and 50.5 percent of the Federal civilian health care expenditures. The elderly consume more over-the-counter and prescription drugs than any other segment of the American population. The current figure of 25 million elderly Americans is growing rapidly and will drastically increase in the future. Health and health care will continue to be major concerns.

The need for health education as we age is obvious, Senior Americans need to be educated about preventive measures they can take which could increase their life expectancy, and/or increase the quality of their lives. They need to be participants in their own health care, not just passive recipients of medical treatment. They need to have the chance to learn about themselves and about opportunities for wellness. They need to be allowed to take personal responsibility for their own health and welfares. This is what health education is all about.

Although the Association for the Advancement of Health Education is supportive of H.R. 4472, we question the exclusion of many health educators from the provision of health education as outlined in the bill. By restricting the delivery of health education services to Schools Public Health, the vast expertise and resources of many of the nation's health educators are left untapped. We think this should not be allowed.

Health education professionals are trained in health and education. They are knowledgeable not only of the technical aspects of the health field, but are also skilled in the technique of communicating this knowledge to others. Their training in education is crucial.

This bill provides for "the development of uniform, standardized components aimed as specific problems encountered by the elderly, such as diet, mental health, hypertension, etc." These "components" are really curriculum components—and development of curricula is best left to professional educators.

There are currently 23 Schools of Public Health across the United States. Only 14 of these offer public health education degrees. This means that as the bill is now

written, only 14 schools nationwide would be available to serve the needs of 3,300 senior centers and the 9 million seniors in their programs.

The resources of health educators are much more vast. Three hundred and two colleges and universities across the country offer health education degrees. Of these, approximately 175 offer specific degrees in community health education. This includes 127 bachelors level programs, 83 masters level programs, 7 specialist degree programs, and 33 doctoral degree level programs. These schools are distributed across the country, and are much more accessible than the 14 Schools of Public Health which have public health education programs. By including all health educators and health education programs in this bill, the potential services available to the elderly could be increased seven-fold.

Hooking-up community services for the elderly with college and university departments of health education —nationwide—can provide a rich and mutually beneficial exchange of ideas and experiences. A comprehensive department of health education could provide:

Education research concerning health education for the elderly,

Demonstration and model programs for replication,

Model curriculum materials,

Supervised intern experiences,

Regional resource centers,

Evaluation of service delivery, curricula, etc.,

Outreach and promotion of health education services to seniors in the community, and

Consultation and training of existing senior center staff.

The Association for the Advancement of Health Education supports HR 4472, and urges the subcommittee to amend it to include colleges and universities with graduate programs of health education.

Again, I would like to thank you for your concern for the elderly, and support of health education.

Thank you.

STATEMENT OF NEIL GALLAGHER, CHAIRMAN, HEALTH SCIENCE DEPARTMENT, TOWSON STATE UNIVERSITY, TOWSON, MD

Dr. GALLAGHER. Thank you. On behalf of my colleagues and the Association for the Advancement of Health Education, I thank you for the opportunity to address the issue of health education for the elderly Americans.

In concert we applaud you and commend you for considering H.R. 4472.

I come before you today in my role as a health educator to pose some questions and to suggest an addition to H.R. 4472. For the past several years as a health educator in the Baltimore metropolitan area, I have been conducting preretirement seminars concerning health education for the industries in the Baltimore metropolitan area, and their response of the participants is just overwhelming.

Why wasn't this information provided before? Where can I get this information? Are there specific people who are trained to provide this information? And they are very much interested in learning about this and taking positive steps to improve their health status.

Their questions range from what preventive measures can be taken to increase my life expectancy and how to increase the quality of life. They want to be participants in their own health care.

But they suffer from what I call, and this is my acronym, FIGS [fear, ignorance, gullibility and superstition]. They want to learn more about their health and they want to know what health education programs are available.

The Association for the Advancement of Health Education supports, wholeheartly supports, H.R. 4472, and as part of the 30,000 members of the American Alliance of Health, Physical Education, Recreation and Dance, the association speaks for concerned health educators.

So on behalf of these health educators, I pose the following questions:

Why are so many health educators excluded from the provision as outlined in the bill?

Why is the delivery of health education restricted to the schools of public health when many universities and colleges provide programs concerning community health education?

My testimony contains data concerning qualified health educators, and concerning those schools of public health, those 23, and the 14 that have the public health education segment.

I feel if we are concerned about health education for the elderly Americans, shouldn't we seek to disseminate this information as widely as possible? Therefore, I urge the subcommittee to amend H.R. 4472 to include colleges and universities with graduate programs of health education.

This concludes my testimony.

Mr. CHANDLER. Thank you, Dr. Gallagher. I apologize for being late. I was attending another subcommittee hearing and I have not had a chance to hear your testimony so I won't have any questions for you.

But does counsel have some questions?

Mr. RALEY. If I can just ask some on behalf of Chairman Andrews, yes.

I know Chairman Andrews, particularly since the bill was first introduced, has talked to a number of groups and has of course held hearings—I believe on two occasions out in the field. He is becoming more and more aware and we certainly have gotten some health education ourselves regarding the various entities that are available to help educate seniors.

Would you be able to give us some idea, for example, on the number of schools of education who would have graduate level programs in community education or health education?

Dr. GALLAGHER. Right now there are 302 colleges and universities offering health education degrees. Of these approximately 175 offer specific degrees in community health education. This includes 127 bachelor level programs, 82 master level programs, 7 specialists degrees and 33 doctoral degrees, and these schools are distributed across the country and are much more accessible than the small number of schools of public health.

Mr. RALEY. Aside from schools of education, would there be others? Our bill, as you know, does talk about schools of public health and also references institutions with capabilities in the medical sciences. Besides those, would there be other areas or other specialties, other departments that we ought to look at for assistance as well as schools of education and schools of public health for medical sciences?

Dr. GALLAGHER. There are many professional schools providing qualified nurses, pharmacists, et cetera, who could teach in the area. We use these in the Maryland metropolitan area. As a matter

of fact, the Waxter Center which will be heard from later on extensively uses interns from our program and other programs, so there are schools, nursing schools, pharmacy schools that provide community health education.

Mr. RALEY. One of the things we have become increasingly aware of, as we talk about health training and education for the elderly, concerns the differences in health care needs of the elderly; certainly the differences in an 84-year-old person who might be home bound as opposed to perhaps a 60-year-old who may be in perfectly good health.

What kinds of things do you think we could do with the health education program that would fit the needs of these various groups?

Dr. GALLAGHER. We could probably take a page from the book of the home-bound students right now and that is when a student is home-bound we can send educators into the home so the student does not fall behind. I think we can learn from that and provide the same type of education for the elderly Americans.

Mr. RALEY. Mr. Chairman, that is all of the questions I have.

Mr. CHANDLER. One question does come to mind. I want at a proper point to enter in the record a statement by the Honorable Claude Pepper, who speaks about almost half of the people over 75 who report no limitations of activity, only 20 percent require the help of another person, and so on. H.R. 4472 identifies the age 60 as the beginning of senior status.

Do you see this as an appropriate age?

Dr. GALLAGHER. No, sir.

Mr. CHANDLER. What do you consider to be more appropriate?

Dr. GALLAGHER. Whenever we put a chronological limitation beginning or ending I become somewhat concerned. If it was open to elderly Americans, depending on how that elderly American wanted to classify themselves, I don't think that you would find a person of the status of a Bob Hope, 82 years of age, considering himself an elderly American. I do believe that if we think of it maybe in the area of 65 to 70, using some of the data as the individual goes past 65 into 70 and 75, their needs for health care delivery are increasing.

So I don't like putting an age limitation.

Mr. CHANDLER. Thank you very much, Dr. Gallagher.

At this point in the record, I would like to enter in behalf of the Honorable Claude Pepper, chairman of the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging, his complete statement and thank him for making that available to the committee.

[Prepared statement of Congressman Claude Pepper follows:]

PREPARED STATEMENT OF HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA AND CHAIRMAN, SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE OF THE HOUSE SELECT COMMITTEE ON AGING

Mr. Chairman, ladies and gentlemen, distinguished guests. It is a pleasure for me to be here today and speak in support of H.R. 4472, the Older Americans Personal Welfare, Education, and Training Act, a bill I believe should be favorably reviewed by this subcomiittee and the full committee at the earliest possible opportunity.

As chairman of the House Select Committee on Aging's Subcommittee on Health and Long-Term Care, I have found that most of our elderly citizens are not totally

disabled waiting to die. Rather, they represent a vibrant part of our society—trying to maintain their ability to function in society as long as possible.

Almost half of the people over 75 report no limitations of activity. Only 20 percent require the help of another person in carrying out their usual activity. Twenty-eight percent report their health is excellent and another 40 percent as good. They need our help in preventing needless disability and institutionalization. Over a 15 month period, about 5 percent of women and 3 percent of men lose their ability to function in the community. About 2 percent of women and 1 percent of men will enter a nursing home. By age 75+, 10 percent of the elderly reside in a nursing home. Some of this institutionalization and loss of functional status is preventable.

Physical activity and good nutrition, especially adequate intake of calcium may prevent osteoporosis, the most important cause of disability among older women and the main reason for the high rates of hip fractures.

Screening, and effective treatment of hypertension will prevent strokes, the third leading cause of death among the elderly and a major cause of disability, 214,000 or 16 percent of all nursing home residents in a 1977 national study suffered from stroke. Many of these strokes are preventable by early diagnosis and treatment of hypertension.

Over medication and misuse of drugs often lead to serious side effects among elderly including depression, dizziness, falls and fractures. A recent study noted that there were four and a half million elderly psychotropic drugs. On the average, these elderly had at least 5 prescriptions for psychotropic drugs. These drugs accounted for 10 percent of all drugs for the elderly. Good health education could help prevent the misuse of prescriptions and non-prescription drugs by the elderly. The proper use of drugs for the treatment of heart disease will reduce unnecessary complications and decrease hospitalization.

Good health education plays a key role in the prevention of the complication of diabetes mellitus. Such simple health education activities such as proper foot and skin care and diet will prevent major complications of diabetes including the amputation of a limb. Nutritional therapy may prevent the need for early dialysis therapy.

Vision and hearing testing and proper treatment evaluation can prevent some of the blindness and deafness of older citizens

The social and economic problems of the elderly have been previously described. A very high percentage of the elderly are widowed women who live alone. Their incomes are very limited. The social isolation can have a devastating effect on both physical and mental health. Suicide rates are highest for the elderly, especially older men. This social isolation and depression are important causes of suicide. Clearly, suicides are preventable by recognition of this depression and enhanced social supports as provided by the multi-purpose senior citizen centers. Most of our health care efforts are directed to the treatment of disease, especially in the last months of life. Our senior citizens want to remain active and useful. The Older Americans Personal Welfare, Education and Training Act will be important for our senior citizens. Preventive medicine and health education must have the highest priority in our health care system, especially for senior citizens.

Thank you.

Mr. CHANDLER. Our next witness will be Dr. William F. Bridgers, dean, School of Public Health, University of Alabama in Birmingham, AL.

Dr. Bridgers, nice to have you with us today.

[Prepared statement of Dr. William F. Bridgers follows:]

PREPARED STATEMENT OF WILLIAM BRIDGERS, M.D., DEAN OF THE SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF ALABAMA, BIRMINGHAM, AL, AND PRESIDENT, ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

Mr. Chairman, and members of the Committee, I am William Bridgers, M.D., Dean of the School of Public Health at the University of Alabama in Birmingham, and President of the Association of Schools of Public Health, on whose behalf I am appearing today. The Association appreciates the opportunity to testify on behalf of this legislation. We strongly support H.R. 4472 and applaud your continuing efforts on behalf of the elderly of this country. As you know, those of us from Schools of Public Health are particularly enthusiastic about this bill because we feel that it recognizes the important role health education, health promotion and disease prevention can play in improving the health of our older Americans and helping to control the spiraling costs of medical care.

The concept of health promotion and disease prevention in improving health and controlling medical care costs is deeply rooted in the 23 U.S. Schools of Public Health and we are pleased to note an emerging general acceptance of this concept. But although we in public health use the term prevention of disease in referring to the end result of our interventions, we are really attempting to achieve something more. We are, in fact, not concerned only with the negative concept disease prevention, but with the positive concept of insuring vitality and this is the idea of particular importance in reducing the burden of dependency for our elderly citizens. We highly commend your recognition of this fact and your willingness to allow us to play a role in this important piece of legislation.

We are all well aware of the fact that our older citizens represent the fastest growing segment of our population. Presently Americans over the age of 65 represent 11 percent of our population, a figure which is expected to double in the next fifty years. Many health problems of the elderly are due in large part to chronic diseases and it is estimated that six million older citizens suffer from chronic diseases that require long-term care in non-institutional settings. In addition, the elderly often suffer from accidents, loneliness, depression and isolation, all of which play an important role in the overall health problems faced by our elderly. We believe that application of health education methods can have a profound effect on many of these health problems.

We also contend that such health promotion and disease prevention activities will provide a financial pay-off as well. Although the elderly make up only 11 percent of the population, the U.S. spends more than half of its federal health care dollars on the elderly. As our population grows older, we can expect to see the percent of these expenditures grow. We believe that a policy of providing health promotion and disease prevention can make a significant contribution to stemming these medical care costs because most of these costs are attributable to acute episodes of illness which may be prevented by investing in routine health maintenance and education for our elderly.

The problems I have outlined thus far provide ample reason for why this bill, designed to provide health education and training focused specifically on the needs of older Americans, is so important. This bill provides a cost-effective means to design and implement programs to benfit the elderly through the use of the existing 3,300 senior centers which serve over 9 million Americans and by utilizing the resources of the 23 U.S. Schools of Public Health.

The bill you are proposing represents an intelligent and humane means of addressing the critical need for effective health education for many of our older Americans.

H.R. 4472 is firmly grounded in several fundamental health education principles in its appreciation of "face to face" versus more indirect mass communications approaches and in its concern with bringing educational programs to the people rather than expecting the people to come to them. Another of its major strengths is that it provides a meaningful way for the elderly to contribute to the development of their own program by allowing for an exchange of ideas between the elderly in senior centers and students and faculty from Schools of Public Health.

I would like to now turn my attention to a brief discussion of the special types of education, training and experience Schools of Public Health bring to proposed programs.

Schools of Public Health provide the appropriate vehicle for designing, implementing and evaluating health education and training services for older Americans because the Schools of Public Health have as a central focus the prevention of disease and promotion of health through research, education and community service and because of the interdisciplinary nature of the curricula they offer.

For example, health education and behavioral sciences are an integral part of the curriculum of Schools of Public Health. As you are aware, many of our students specialize in these areas at the masters and doctoral level. We can also draw upon expertise in the disciplines of epidemiology and biostatistics which are also basic to the curriculum of Schools of Public Health. Using the tools provided by these disciplines, our faculty and students are trained to not only design and implement meaningful programs but also to effectively evaluate these programs using public health population surveillance and screening techniques. In addition, although Schools of Public Health are concerned with aspects of health as it pertains to all population groups, a majority of the Schools of Public Health offer specialized education and training in gerontology. Such specialized education and training provide a wide range of opportunities for our students. These include specialization in gerontology at the masters and doctoral level, certification in long-term care administration and

concentrations in aging in epidemiology, behavioral sciences, health education and health administration programs.

The provision of community service is also of great importance to Schools of Public Health and there are many schools involved in outreach programs benefiting the elderly. One such community program which has received national attention, the Tenderloin Senior Outreach Program, was started by three graduate students and Professor Meredith Minkler from the University of California School of Public Health in Berkeley. The project now involves residents of eight hotels in San Francisco's high crime Tenderloin district and nearly 100 students. The program concentrates on providing safety, friendship, health and proper nutrition for the elderly residents of the Tenderloin. Although specific results are hard to measure, the founders report that the program has influenced such developments as:

A 26 percent drop in crime during the last year, which police have attributed in part to the program.

Help from 48 businesses, bars and restaurants that act as safehouses, where community residents can turn during an emergency.

A mini-market set up every week to offer low-cost fruits and vegetables to the elderly.

"Immeasurable" gains in self-esteem and innumerable friendships for those in the program.

This program provides an excellent example of how, with only a small monetary investment, the resources of students and faculty of Schools of Public Health can be marshalled to provide an effective program for the elderly.

We feel that through this bill we in Schools of Public Health will be able to utilize this varied experience, education and training to benefit older Americans on a national basis.

Finally, I would like to say that this bill has another critical component which is not spelled out directly and yet which, in the long run, may constitute one of its most valuable benefits.

I refer to the profound influence which enactment and implementation of this bill may have on geriatric and gerontological health manpower development, research and training through its conscious involvement of faculty and students in the nation's graduate Schools of Public Health. The educational opportunities which will be provided for both our elderly and for Schools of Public Health can only result in significant gains for the entire nation.

Once again I would like to say that the Association of Schools of Public Health supports this bill and congratulates you on your thoughtful approach to a public health problem which deserves major national attention.

STATEMENT OF WILLIAM F. BRIDGERS, M.D., DEAN, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF ALABAMA, BIRMINGHAM, AL

Dr. BRIDGERS. Thank you, Mr. Chairman.

I am Dr. William Bridgers, dean of the School of Public Health at the University of Alabama in Birmingham, and president of the Association of Schools of Public Health, on whose behalf I am appearing today.

We appreciate the opportunity to testify on behalf of this legislation, and we strongly support it. We applaud your efforts to reduce the burden of dependency that so frequently accompanies the diseases of the elderly but need not be an inevitable consequence of simply growing older with this burden.

Your bill clearly recognizes the important role health education and disease prevention strategies can play in improving the vitality of our older citizens.

Schools of public health were founded on the concept of disease prevention, and their role in the first public health revolution, the control of infectious disease, is well known. The same strategies of surveillance to identify risks, design of intervention methods, their implementation and evaluation are applicable to the modern burden of illness from chronic disease, and we are pleased to note

an emerging general acceptance of the importance we have long attached to prevention strategies.

Although we in public health often use the term, prevention of disease, in referring to the results of our interventions, we are really attempting to achieve something more, as I noted a moment ago. We are not as concerned with the negative concept of disease prevention as with the positive notion of assuring vitality. This idea comes through quite clearly in your legislation.

We are all well aware that our older citizens represent the fastest growing segment of our population. We also are becoming increasingly better informed about the many health problems of the elderly due in large part to chronic diseases that developed insidiously over many years.

The dependencies accompanying these conditions are often exacerbated by feelings of loneliness, depression and isolation, and are compounded by inactivity, poor nutrition and overmedication. Many of these exacerbations can be avoided by application of health education and health promotion techniques.

We also are confident that such health promotion and disease prevention activities could provide a financial payoff as well by reducing not only the number and extent of acute exacerbations but the necessity for medical interventions either in the ambulatory or inpatient setting.

The problems I have outlined and the potential for inexpensive strategies to deal with them provide ample reason why this bill is so important. We recognize the importance for the elderly to contribute to these solutions.

Indeed, bringing to bear the wisdom of citizens who have experienced living for 60 or more years, through the use of the existing senior centers and perhaps other settings, and through the use of the talents and expertise of the schools of public health, makes great good sense.

In my written testimony which I have submitted, I note the interdisciplinary nature of our schools and the several different areas of knowledge that must be used to address the mission of this bill. Health education and other behavioral sciences are an integral part of the curriculum of schools of public health.

We can also draw upon expertise in the basic disciplines of epidemiology and biostatistics and in public health management. Using the tools provided by these disciplines, we can design, implement meaningful programs, and evaluate them.

My written testimony also notes the recognition by our schools of the importance of community service, of face-to-face programs brought to the people rather than expecting the people to somehow find them.

I want especially to call to your attention one such, the Tenderloin Senior Outreach Program, run by the School of Public Health at Berkeley. Certainly there are elements of that program that can serve as a guide in the implementation of your proposal.

Once again I would like to say that we support this bill and congratulate you on your thoughtful approach to a public health problem which deserves major national attention.

Thank you.

Mr. CHANDLER. Thank you, Dr. Bridgers.

Do you have questions, counsel?

Mr. RALEY. If I might, please. One of the discussion points we are continuing to talk about is the cost of providing health education. If we are speaking in terms of demonstration projects, would you be able to give us some idea about just what that cost might be and how much assistance, a given project, let's say, in a school of public health, would need to carry out such a program?

Dr. BRIDGERS. You are talking about pilot-run feasibility types of studies?

Mr. RALEY. Perhaps. I would probably want to talk more about demonstrations rather than studies.

Dr. BRIDGERS. Sort of the translation of what we already know into activities?

Mr. RALEY. Right. In other words, if we were going to try a demonstration project in Alababma, in the Birmingham area, involving five or six senior centers, with the School of Public Health doing a training program for them what would be an appropriate cost figure? An important part would be evaluating the program to see what worked and didn't so we could improve upon it.

Dr. BRIDGERS. It's always risky to try to place a number on that.

Mr. RALEY. Be very general. We are trying to get some ballpark figure.

Dr. BRIDGERS. Based on analogy to two or three projects we have ongoing now, smoking cessation projects, somewhere around $150,000 a year per effort strikes me as being about right.

Mr. RALEY. Thank you very much.

Mr. CHANDLER. Thank you, counsel.

Dr. Bridgers, the bill appears fairly specific about which universities would qualify for funding under this bill. Under section 704 (b)(1), public and private institutions of higher education with capability of public health, do you know how many schools would qualify?

Dr. BRIDGERS. I heard a comment earlier only 14 would qualify.

Mr. CHANDLER. That was from earlier testimony, that is correct.

Dr. BRIDGERS. There are 23 accredited schools of public health. They all carry out these functions of designing and implementing programs and evaluating them, coordinating them.

I can't on the surface see why the purpose of the bill can't be addressed by all 23, by any of the 23.

Mr. RALEY. How are they geographically distributed, do you know?

Dr. BRIDGERS. In 17 States and Puerto Rico. There is one in Hawaii and the other extreme would be Puerto Rico, and then they are scattered across the east coast and largely throughout the country, except there is a void in the far West.

Mr. RALEY. State of Washington?

Dr. BRIDGERS. No; no void there. But if you just leave Seattle and come this way it will take you a while to get to the next school.

Mr. CHANDLER. There is quite a comprehensive cooperative effort between the schools of medicine. As I am sure you are aware, through Oregon, Washington, Alaska, Montana, Idaho.

Dr. BRIDGERS. Yes.

Mr. RALEY. So they could probably overcome any difficulty that that might represent.

Dr. BRIDGERS. Right.

Mr. CHANDLER. I might ask you to comment also about the question of age, age 60, how appropriate you feel that is.

Dr. BRIDGERS. I assumed, no doubt incorrectly, that that was a constraint placed by the legislation that this was amending. If that is not the case, then I don't see anything magic about age 60, until one defines physiological age instead of chronological. I have the same general comment that the last person did.

Mr. CHANDLER. Subsection D identifies six major health problems: Diet, mental health, hypertension, retirement, health insurance, which isn't a direct health problem, obviously, and hypothermia.

Do you feel that is inclusive enough? Should that be broadened?

Dr. BRIDGERS. I would broaden it, but I think the language to broaden it is elsewhere, like the overmedication problem is a major one and that is covered in the next one.

Without looking to see if items in D have not been covered elsewhere, I suspect I would not recommend any broadening of D.

Mr. CHANDLER. I believe that is all of the questions I have, Dr. Bridgers.

Thank you.

Dr. BRIDGERS. Thank you, Mr. Chairman.

Mr. CHANDLER. Our next witness is Mary Jane Lyman, executive director, Waxter Center for Senior Citizens, Baltimore, MD.

Good morning.

[Prepared statement of Mary Jane Lyman follows:]

PREPARED STATEMENT OF MARY JANE LYMAN, DIRECTOR, WAXTER CENTER FOR SENIOR CITIZENS, BALTIMORE, MD

Mr. Chairman, it is a pleasure to present testimony on the Older Americans Personal Welfare Education and Training Program, a proposed amendment to The Older Americans Act. My name is Mary Jane Lyman and I am the Director of the Waxter Center for Senior Citizens and the Deputy Director of the Commission on Aging and Retirement Education in Baltimore, Maryland.

The City of Baltimore has 140,700 persons age 60 and over. Of these 40,000 are 75 plus. Through its Commission on Aging, which is also the area agency, the City serves its elder citizens through a comprehensive system of care. The Waxter Center for Senior Citizens, the service arm of the Commission, was funded through a 3.8 million dollar bond issue passed by voters in 1967. Opening in May of 1974, the Center culminates 10 years of service to over 20,000 Baltimoreans this May.

As a city agency, we are mandated to serve all city residents 60 and over in our seven-day-a-week program. The center offers a full range of services: health (including primary care, health monitoring, full dental services, optometry, occupational and physical therapy); social work services of both individual and group nature; information and referral services; transportation and special services to the blind and mobility impaired; recreational and educational programs (encompassing physical education, music, foreign languages, GED preparation as well as college level courses); adult medical day care for 40 seriously impaired seniors; employment services under Title V of the Older Americans Act and Jobs Partnership and Training Act; and volunteer training and service opportunities.

We are also one of several sites of the only Geriatric Area Health Education Center in the United States funded through the University of Maryland School of Medicine. This project trains graduate students in medicine, nursing, pharmacy, dentistry, social work and law in community based geriatric sits offering service to that community and education to the students. Our 55,000 square foot facility is barrier free and our current membership is over 3,000 seniors with a daily attendance of 200 to 500 persons seven days a week. We serve as a laboratory to a number of disciplines and intermittently serve as a research site for the Gerontological Research Center of National Institute of Aging in Baltimore and to the Johns Hopkins School of Hygiene and Public Health.

It is from this frame of experiential knowledge that we support the purposes and concepts of this proposed amendment to The Older Americans Act.

Since 1974 when the Waxter Center opened with 500 members transferred from the pilot project, initiated in 1964, we have seen a whole "generation" of older persons come and go. The original 500-member profile indicated that members were white collar, mostly widows, aged 65 to 75, with low income. They preferred social and educational activities and came to the center for enrichment, culture, and socialization.

In 1982 we concluded a three-year research demonstration project, funded by The Older Americans Act, testing whether disabled persons could be served in a multipurpose senior center. The research on that grant indicated rather drastic changes in the profile of regular membership. Younger couples, rather than widows and widowers, with higher retirement incomes, higher levels of education, from blue collar backgrounds and 40 percent minority were joining the Waxter Center. Their interests expanded beyond traditional education and recreation to health monitoring, fitness, nutrition counseling, employability and new educational demands. They reflected the characteristics of younger persons entering the aging cohort.

Within the past two years we have had a dramatic increase in members seeking fitness programs. Presently, we have advanced physical fitness classes, swimming, yoga, aerobics, volleyball, walking, jogging, and dance groups. Our physical fitness coordinator discovered that many members were being referred by their physicians for fitness programs to reduce hypertension. In an informal study where blood pressure, chloresterol levels, weight and certain mobility and endurance measurements were taken at program initiation and three months later, it was discovered that both diastolic and systolic pressures were drastically reduced and mobility and endurance increased measurably.

Our AHEC primary care physicians and nurse practitioners, who have health monitored 700 persons in the past two years, have conducted both formal and informal sessions on management of hypertension and diabetes with the members. These sessions are conducted with both the well-elderly and with the adult medical day care clients and their caregivers.

While we are just beginning to enter health utilization data into our computer we have some substantial statistics on the numbers of older persons who are taking a new look at prevention and health education. Classes in yoga, weight loss, use of medications and certainly health care costs have been most popular. Women's issues, bereavement, depression and coping with disabilities are treated in group sessions by our social work staff. It is our belief that whenever older persons gather, these issues and concerns will emerge. Older persons gather in senior centers, and it is there that these issues can be addressed in an atmosphere of wellness and growth.

In Baltimore there are 15 neighborhood senior centers coordinated through a Directors' Council. They serve the Korean, the deaf, the minority, and mixed populations that reflect Baltimore's ethnicity and offer nutrition, education, recreation, transportation, volunteer, and health services. To facilitate the current trends of interest the Baltimore Directors' Council is planning a citywide conference in June on "traditional and non-traditional approaches to health care".

Surely this amendment reflects an "idea whose time has come". A thoughtful program in preventive health care designed by professionals in appropriate fields, standardized and implemented through multipurpose senior centers and properly evaluated will assist older persons in attaining a higher quality of remaining life and ultimately reduce health care costs. The concept is one that all practitioners in the gerontological field will support.

Across the country senior centers, congregate food sites, local health departments, state offices and area agencies on aging, health maintenance organizations, and colleges and universities have conducted and are conducting a myriad of health education, prevention, maintenance and rehabilitation classes and groups. Because of these already existing resources, some tried and many in development phases, I respectfully suggest that this Committee may wish to consider alternative legislation to a new title of the Older Americans Act. A number of models conceptualizing the purposes of this proposal have been tried in the Baltimore area. Perhaps it would be worthwhile to consider trials of a number of models across the country with a year or two for development, implementation, and meaningful evaluation. Placing the mandate in Title IV—Research and Demonstration of the Older Americans Act, may be feasible.

In discussion with my colleagues, it appears that several options may be viable. An adult or health educator placed in a state office on aging, an area agency, or in a major senior center could negotiate courses and instructors from a university with

multiple disciplines, such as, medicine, nursing, dentistry, pharmacy, or a school of public health, to deliver the education and training programs in a variety of sites, senior centers, congregate food sites or even shopping centers, some heavily populated with older persons. Colleges or universities with schools specializing in gerontology, such as the University of Southern California, could and certainly have produced valuable education courses in retirement, health prevention, stress, and illness management, etc. A wealth of material and resources already exist. For instance, Maryland's Geriatric Area Health Education Center has specialized in these areas as has the University of Maryland School of Pharmacy which has recently received private funding to continue its Elder Ed program. On Monday, March 26, the program was given an Award of Excellence by Health & Human Services Secretary Heckler.

It is my concern that the educational product be delivered to where elder persons congregate, which is generally not on university campuses. The Older Americans Act has mandated and defined the focal point concept since 1973. Flexibility to allow a number of options may well be the key to the success of this program. The National Institute of Senior Centers under the umbrella of the National Council on Aging has had phenomenal success with its Humanities program. Manuals, audio tapes, and discussion guides on a wide range of issues in history, arts and humanities have been made available to senior centers and nutrition sites. The advice of this singular body, representing senior centers across the country, should be sought. The knowledge needed exists but the packaging, marketing, and delivery of the service is crucial. While our experience in Baltimore indicates that older persons are taking responsibility for their own lives and health, they are doing it on their own terms. Traditional college and university approaches to teaching and instruction may not be acceptable to elders. Health education must move from a "disease" model where diagnosis is followed by treatment to a truly preventive model. The dialogue and interaction between seniors and experts in this proposal may well initiate a new era in quality of life for all ages.

In summary, the concept of the Older Americans Personal Welfare Education & Training program is an exciting viable one. Its development, implementation, and evaluation should carry out the Congressional intent of the Older Americans Act.

STATEMENT OF MARY JANE LYMAN, EXECUTIVE DIRECTOR, WAXTER CENTER FOR SENIOR CITIZENS, BALTIMORE, MD, ACCOMPANIED BY JOYCE LEANSE, ASSOCIATE DIRECTOR, NATIONAL COUNCIL ON THE AGING, DIRECTOR OF PROFESSIONAL AND COMMUNITY SERVICE, WASHINGTON, DC

Ms. LYMAN. Good morning.

Mr. CHANDLER. Is Ms. Leanse here? Would you like to join Ms. Lyman at the table there?

Ms. LYMAN. It's a pleasure to present testimony on the Older Americans Personal Welfare Education and Training Program, a proposed amendment to the Older Americans Act.

My name is Mary Jane Lyman and I am the director of the Waxter Center for Senior Citizens and the deputy director of the Commission on Aging and Retirement Education in Baltimore, MD.

The city of Baltimore has 140,700 persons age 60 and over. Of these, 40,000 are 75 plus. Through its Commission on Aging, which is also the area agency, the city serves its elder citizens through a comprehensive system of care. The Waxter Center for Senior Citizens, the service arm of the commission, was funded through a $3.8 million bond issue passed by voters in 1967. Opening in May 1974, the center culminates 10 years of service to over 20,000 Baltimoreans this May.

As a city agency, we are mandated to serve all city residents, 60 and over, in our 7-day-a-week program.

My written testimony indicates the kinds of services we offer. Suffice it to say that we are the most comprehensive multipurpose senior citizen center in the United States that we know of.

The center offers a full range of services; health, including primary care, health monitoring, full dental services, optometry, occupational and physical therapy; social work services of both individual and group nature; information and referral services; transportation and special services to the blind and mobility impaired; recreational and educational programs, encompassing physical education, music, foreign languages, GED preparation as well as college level courses; adult medical day care for 40 seriously impaired seniors; employment services under title V of the Older Americans Act and Jobs Partnership and Training Act; and volunteer training and service opportunities.

We are also one of several sites in the only Geriatric Area Health Education Center in the United States funded through the University of Maryland School of Medicine. We recognize that North Carolina has the best known AHEC in the United States, but we are the only geriatric.

This project trains graduate students in medicine, nursing, pharmacy, dentistry, social work, and law in community-based geriatric sites offering service to that community and education to the students. Our 55,000-square-foot facility is barrier-free and our current membership is over 3,000 seniors, with a daily attendance of 200 to 500 persons 7 days a week.

We serve as a laboratory to a number of disciplines and intermittently serve as a research site for the Gerontological Research Center of National Institute of Aging in Baltimore and to the Johns Hopkins School of Hygiene and Public Health.

It is from this frame of experiential knowledge that we support the purposes and concepts of this proposed amendment to the Older Americans Act.

Since 1974, when the Waxter Center opened with 500 members transferred from the pilot project initiated in 1964, we have seen a whole generation of older persons come and go. The original 500-member profile indicated that members were white-collar, mostly widows, aged 65 to 75, with low income. They came to play cards, go to lectures, listen to music. They preferred social and educational activities and came to the center for enrichment, culture, and socialization.

In 1962, we concluded a 3-year research demonstration project, funded by the Older Americans Act, testing whether disabled persons could be served in a multipurpose senior center.

As a part of the research, we did a profile of the membership, which had some surprising implications for us. We found that over the 8-year period, our membership had changed drastically. People joining the Waxter Center were younger, were couples, were mostly at least 50-percent minority, with higher incomes and higher educations. And they had a whole new set of demands for the center.

They were particularly interested in recreation, health monitoring, recreation of a fitness type, nutrition counseling, employability, and new educational demands. They were indeed a new cohort.

So for the past 2 years, we have seen a dramatic increase in members seeking fitness, and we have listed the activities they wanted.

We found many of these wanting a fitness program were being referred by their physicians in order to reduce their hypertension, and so we conducted an informal study where blood pressure, chloresterol levels, weight and certain mobility and endurance measurements were taken at program initiation, and 3 months later it was discovered that both diastolic and systolic pressures were drastically reduced and mobility and endurance increased measurably.

Our AHEC primary care physicians and nurse practitioners, who have health monitored 700 persons in the past 2 years, have conducted both formal and informal sessions on management of hypertension and diabetes with the members. These sessions are conducted with both the well-elderly and with the adult medical day-care clients, who are seriously impaired, and their caregivers.

While we are just beginning to enter health utilization data into our computer, we have some substantial statistics on the numbers of older persons who are taking a new look at prevention and health education.

We are finding more and more people, by their own choice, are taking more care in their prevention and health education. Also, we add to women's issues bereavement, depression, coping with disabilities, and so forth, which also led to poor health, as I am sure you know. It is our belief that whenever older persons gather, these issues and concerns will emerge. Older persons gather in senior centers, and it is there that these issues can be addressed in an atmosphere of wellness and growth.

Our experience in Baltimore goes way beyond the Waxter Center, as reflected in the next testimony. In Baltimore, there are 15 neighborhood senior centers coordinated through a directors' council. They serve the Korean, the deaf, the minority, and mixed populations that reflect Baltimore's ethnicity and offer nutrition, education, recreation, transportation, volunteer, and health services. To facilitate the current trends of interest, the Baltimore Directors' Council is planning a citywide conference in June on traditional and nontraditional approaches to health care, with such things as even acupuncture demonstrations.

This amendment is one we support. It is an idea whose time has come. A thoughtful program in preventive health care designed by professionals in appropriate fields, standardized and implemented through multipurpose senior centers and properly evaluated, will assist older persons in attaining a higher quality of remaining life and ultimately reduce health care costs. The concept is certainly one that all practitioners in the gerontological field will support.

Across the country, senior centers, congregate food sites, local health departments, State offices, and area agencies on aging, health maintenance organizations, and colleges and universities have conducted and are conducting a myriad of health education, prevention, maintenance and rehabilitation classes and groups.

Because of these already existing resources, some tried and many in development phases, I respectfully suggest that this committee may wish to consider alternative legislation to a new title of the Older Americans Act.

A number of models conceptualizing the purposes of this proposal have been tried in the Baltimore area. Perhaps it would be worthwhile to consider trials of a number of models across the country with a year or two for development, implementation, and meaningful evaluation. Placing the mandate in title IV, Research and Demonstration of the Older Americans Act, may be feasible, as opposed to a new title.

I go through some of the options in my written testimony. For instance, an adult or health educator would be placed in a State office on aging, an area agency or major senior center and could negotiate courses from existing universities with multiple disciplines such as we have in Baltimore, medicine, nursing, the whole line of professional schools, including the School of Public Health.

A number of education and training courses could be delivered in a number of cities, senior centers, even shopping centers, and I have attached to the testimony a yellow sheet which is something we are doing in Baltimore and, if you will, when you have an opportunity, look at the page that says Health Services.

If you will look at the nature of the kinds of programs that are being offered here, you will see that there is already interest in this program. This is partially funded by the Administration on Aging, a program, ever innovative, that started in St. Louis and is now in Baltimore. It opened in October. Over 900 people have signed up and these courses have an average of 50 to 60 in attendance at each lecture, so the need is there, the older people want it.

We need to be looking at how it can be best delivered.

[The information referred to follows:]

OASIS

A UNIQUE CONCEPT FOR ENRICHING THE QUALITY OF LIFE FOR OLDER ADULTS

APRIL - JUNE 1984

Hecht's Lower Level Reisterstown Plaza

HECHT'S

Older Adult Service and Information System (OASIS) is a cooperative program of the Baltimore City Commission on Aging and Retirement Education, the Area Agency on Aging, the Maryland Institute, College of Art/Arts and Aging Program, and Hecht's. In addition, a large number of agencies will participate in this exciting community effort to bring together a wide variety of educational, informational and cultural experiences for older adults.

Individuals 60 years of age and older may join OASIS Club by registering at Hecht's, Reisterstown Road Plaza, lower level, 10:00 a.m. to 3:00 p.m. Tuesday through Friday, beginning April 3. (Special registration for classes and membership will be held Monday, April 2.) There is no membership fee. Members will receive a card entitling them to participate in OASIS programs and special events. Classes, lectures and services will be available every Monday through Friday from 10 a.m. to 3:00 p.m.

The OASIS program originates from the Arts for Older Adults Program and the University of Missouri at St. Louis with support from the Administration on Aging.

We appreciate and gratefully acknowledge the cooperation and support of the OASIS Advisory Committee and Northwest Senior Center.

INFORMATION CENTER

OASIS Club will be open 10:00 a.m. to 3:00 p.m., Tuesday through Friday. Volunteers will be on hand during those hours to answer questions you may have or provide referrals you may need. Please feel free to come in for any assistance during these hours.

HERE'S HOW TO REGISTER FOR OASIS MEMBERSHIP

The OASIS Club will be open for registration Tuesday through Friday from 10:00 a.m. to 3:00 p.m. except holidays. MEMBERSHIP IS FREE and open to all individuals 60 years or older. There will be a small fee for some classes and special programs.

For further information on OASIS, please phone The OASIS Center at 358-1498 or phone Barbara S. Rogers, Program Director, at 368-4799

CLASSES AND SEMINARS - APRIL 3 - JUNE 15, 1984

Registration for classes and seminars will be held in the OASIS Club Center, Hecht's Reisterstown Plaza, Monday, April 2, 10 A.M. to 3 P.M. If there is no fee charged, you still must register. Seating is limited.
Please note: There will be no classes the week of April 16 - 20. The OASIS Center will be closed.

MONDAYS

MURAL PAINTING—NO FEE
April 9 - June 25, 10:00 A.M. - 12 Noon
Join this group effort to create a permanent wall display for the Baltimore City offices of the Commission on Aging and Retirement Education.
Instructor: Rodney Cook, B.A., M.F.A., local artist and teacher
(Please note: This class will not meet on April 16 and May 28)

TUESDAYS

CALLIGRAPHY—$5 FEE
April 3 - May 1, 10:00 A.M. - 12 Noon
Learn the techniques of beautiful handwriting using the italic style pen lettering. You will be able to hand-letter posters and address elegant letters and invitations.
Instructor: Susanne Udel

STITCHERY—$5 FEE
May 8 - June 12, 10:00 A.M. - 12 Noon
Learn this fine art of ornamenting fabric with needlework designs. You'll be taught the embroidery techniques of candlewicking, chicken scratch and counted thread. Please bring an embroidery hoop.
Instructor: Pegg Poff

CURRENT ISSUES AND SPECIAL INTEREST SEMINARS—NO FEE
April 3 - June 12, 1:00 P.M. - 2:30 P.M.

POLITICS

April 3	The presidential primaries with Dr. L. Kay Munn, Political Science Department of Goucher College
April 10	An assessment of President Reagan with Dr. L. Kay Munn
April 24	The media and American politics with Dr. L. Kay Munn

BEAUTY

May 1	Color coordination with Mrs. Marilyn Uman, professional beauty consultant
May 8	Make-up and skin care with Mrs. Marilyn Uman
May 15	Wardrobe planning with Mrs. Marilyn Uman

FINANCE
Financial needs of the elderly will be addressed by Dr. Jack W. Taylor, certified financial planner and investment advisor with Creative Financial Concepts, Inc. Topics will include investing, financial strategies and estate planning.

May 22	Finance, Part I with Dr. Jack W. Taylor
May 29	Finance, Part II with Dr. Jack W. Taylor
June 5	Finance, Part III with Dr. Jack W. Taylor
June 12	Finance, Part IV with Dr. Jack W. Taylor

WEDNESDAYS

PHYSICAL FITNESS—$10 FEE
April 4 - June 13, 10:30 A.M. - 12 Noon
Get in shape for Spring. Join the fun and feel better doing it with specially created exercises for older adults. Wear comfortable clothes
Instructor: Nancy Tankelson from California Body Works.

HEALTH SERIES COORDINATED BY THE NORTHWEST SENIOR CENTER—NO FEE

April 4 - June 13, 1:00 P.M. and 3:00 P.M.

April 4	"Medicare and Blue Cross/Blue Shield" The more you know about your benefits, the better protected you will be. Speakers: Stephanie Short, Medicare Service Representative, Blue Cross/Blue Shield of Maryland; and Joanne Unger, Blue Shield Claims Specialist, Blue Cross/Blue Shield of Maryland.
April 11	"Keeping Health Care Cost Under Control" Learn how to avoid the high costs of illness and hospitalization. Speaker: Daniel Murray, Vice President of Finance, Sinai Hospital of Baltimore
April 25	"Oh, My Aching Back" Relief is just a class away. Find out how to alleviate back aches and avert painful back injury. Speaker: Elaine Liebfeld, Physical Therapist, Department of Rehabilitation Medicine, Sinai Hospital of Baltimore
May 2	"Let Your Smile Be Your Umbrella" Avoid needless tooth loss and surrounding tissue disease. Learn up-to-date techniques for the proper daily care of teeth and gums. Speaker: Dr. Myron H. Sachs, D.D.S.
May 9	"With Every Breath You Take" Improve your all-over feeling of wellness with better attention to keeping your lungs in good, healthy condition. Speaker: Gina Westfall, Associate Program Director, American Lung Association
May 16	"The Joys and Sorrows of Aging" Learn how to cope with disappointments and grief while discovering the new experiences and delights of growing older. Speaker: Harry Citron, Director of Social Work, Levindale Hebrew Home and Geriatric Hospital
May 30	"Making Friends With Your Middle-Age Children" At last your children are grown, but the burdens of parenthood remain. Join in a lively panel discussion on the special problems of being parents to middle-age children. Speakers: To include a panel of staff professionals from the Jewish Family and Children Service
June 6	"Stress Affects On Decision-Making" Strategies for relieving stress and making error-free decisions will be presented and discussed. Speaker: Meyer Schlein, Director of Retirement Education, Baltimore City Commission on Aging and Retirement Education.
June 13	"Relax!" Learn recreational and other activities for reducing tension and stress. Speaker: Lynn Lazear, M.S., Program Coordinator, Sheppard Pratt Division of Professional and Public Education

THURSDAYS

HERE'S LOOKING AT YOU—A LOVE AFFAIR WITH BALTIMORE IN LECTURES, FILMS AND TOURS—$20 FEE

April 5 - June 14, 10:30 A.M. - 12 Noon
(Class is limited to 30 members and includes 4 trips)

April 5	"Baltimore Works" and "Elysium," two unusual films depicting various aspects of life in Baltimore.
April 12	Illustrated lecture on Charles Center and the Inner Harbor, by Barbara Bonnell, Director of Information of the Charles Center-Inner Harbor Management, Inc.
April 26	Guided tour of the Inner Harbor, Top of the World Trade Center, The Brokerage, new housing. Lunch at Harborplace or brown bag.
May 3	"A Perfect Lady," a film tribute to Baltimore narrated by Gary Moore; and "The Light of Dawn," a film about the Star Spangled Banner.
May 10	Guided tour of the City Hall and a visit to the Maryland Science Center. Lunch at Lexington Market or brown bag.
May 17	Lecture on Federal Hill and Fell's Point by Carolyn Donkervoet, Director for the Society for the Preservation of Federal Hill and Fell's Point.
May 24	Guided tour of the Peale Museum, Carroll Mansion, Shot Tower, Lloyd St. Synagogue, Public Works Museum. Lunch on Lombard St. or brown bag.
May 31	Lecture: Overview of 20 small museums, including Mt. Clare, the Basilica, Poe House, Lovely Lane Museum, the Flag House, the Public Works Museum. Speaker: Nancy Andryszak, Curator of the Public Works Museum and Chairman of the Baltimore Council of Historic Sites.
June 7	Guided tour of the Peale Museum, Carroll Mansion, Shot Tower, Lloyd St. Synogogue, Public Works Museum. Lunch on Lombard St. or brown bag.
June 14	Lecture: Looking ahead to the Baltimore of the future by Sandra Hillman, Executive Director of the Office of Promotion and Tourism.

PAINTING—$15 FEE
April 5 - June 14, 1:00 P.M. - 3:00 P.M.
Discover your hidden talents and learn to be an "artist." Join the excitement of learning a new and rewarding hobby. Initial supplies provided.
Instructor: Joan Cassis

FRIDAYS

PHYSICAL FITNESS—$10 FEE
April 6 - June 15, 10:30 A.M. - 12 Noon
Get physicall Work out some more, but remember to wear comfortable clothes.
Instructor: Nancy Tankelson from California Body Works

KNITTING—$10 FEE
April 6 - June 15, 1:00 P.M. - 3:00 P.M.
Learn the basics of knitting while learning how to follow written instructions. If you are experienced, this class will help you to make your knitwear look more professional. Initial supplies provided. (If you have knitting needles, please bring them.)
Instructor: Mike Rogers, Maryland Institute, College of Art.

SPECIAL EVENT

May 22, 1:30 P.M. - 3:30 P.M.
A special get-together and party for OASIS members only. To be held in the OASIS Club Center.

Ms. LYMAN. I believe that a wealth of material and resources already exist in the senior center field, and I believe Mrs. Leanse will be speaking to that point.

For instance, our own geriatric health education has already specialized in these areas. And the University of Maryland School of Pharmacy just this Monday received an award from Secretary Heckler for its elderly education program, which is pharmaceutical use, and so forth, approaches for older people.

My concern is that this educational product be delivered to where older people congregate, which is generally not on university campuses. The Older Americans Act has defined the focal point concept and I think that flexibility is a good idea in delivery of this program.

I suggest that the National Institute of Senior Centers, which is under the umbrella of the National Council on Aging, has had phenomenal success with its humanities program which has been packaged and delivered across the country and made available to senior centers and nutrition sites, and certainly advice of this body should be sought.

I think the knowledge exists; the need is there. But I think that the committee needs to look at the packaging, the marketing and the delivery of that service. I think it is crucial.

Our experience in Baltimore indicates that older people are taking responsibility for their own lives and health, but they are doing it on their own terms, and if you meet an older person who doesn't do something on his own terms please introduce me.

Traditional college and university approaches to teaching and instruction may not be acceptable to elders. Health education has to move from a disease model where diagnosis is followed by treatment, to a truly preventive model. I think the dialog between the elderly and the experts in this proposal may have far-reaching implications well beyond this.

In summary, the concept of the Older Americans Personal Welfare Education and Training Program is an exciting, viable one. Its development, implementation and evaluation should carry out the congressional intent of the Older Americans Act.

Thank you.

Mr. CHANDLER. Mrs. Leanse, did you want to go ahead and testify or were you going to make comments?

Mrs. LEANSE. I am here to respond to questions, if it's appropriate.

Mr. CHANDLER. That will be fine.

Counsel, did you have questions of the witness?

Mr. RALEY. Yes, just one, which came up during the testimony.

You were mentioning the National Institute of Senior Centers has a humaneness program which I gather was packaged and, as you said, distributed throughout the senior centers.

Could you describe what that was like and how we might use it as a model?

Ms. LYMAN. I can describe it as a user; Mrs. Leanse's as a conceptualizer.

Mr. RALEY. Both might be helpful.

Ms. LYMAN. This was made available by persons employed and developed by the National Council on Aging, and it was designed to

deal with older people in terms of images of aging, aging in literature, aging in the future, a number of different concepts and approaches to certain educational content.

It was made available in large print manuals, along with audio tapes for people who cannot read, for whatever reasons, and discussion guides were then distributed for discussion leaders to follow.

We have used it at Waxter Center. We have used several of the issues over a period of time, and it has been most successful. But it is something that as a center we wouldn't have done because we don't have those experts in those particular fields to develop the material.

Mrs. LEANSE. I believe that the concept and how it becomes useful in thinking it through for the health promotion program is the idea of a centralized package of materials which could be made available to those places that cannot draw on resources that might be available in the community at the schools of public health, since there are only 23 of them around the country, although I do support the other testimony given that the concept should be broadened and other universities be brought into this planning.

But the idea of a package that would go out, we know from statistics that we have collected that many senior centers, if not all senior centers, and there are roughly about 8,000 senior centers now in the country, are doing something related to health education and health promotion. These usually call in whatever resources are available in the community, so it is on an ad hoc rather haphazard basis.

However, there are many senior centers who have on staff a nurse, or they have placed within a center a nurse supported by the public health agency or another agency in the community. We have done an informal study with 728 responses, which certainly is not representative, but it will give you a feeling where we show nearly 25 percent have a nurse on staff, and another nearly 50 percent, 49.3 percent, have a full-time nurse that is an employee of another agency but located at the center, and we go through all of these other staff people, nutritionists, mental health counselors, physician specialists assistant, part-time dentists, physicians and nurses where they are on the center staff and paid for by the center. Then we go into where they are employed by others.

This is still in draft form, and when it's final I would like to have permission to submit it for the record.

Mr. ANDREWS. Without objection, of course, that will be done.

Go right ahead.

Mr. CHANDLER. Thank you, Mr. Chairman.

Ms. Lyman, I can see why you are excited about your program. Your testimony was delightful and interesting.

I was wondering how much utility you find among the seniors themselves to assist with the conduct of the program. You obviously have retired physicians and dentists and PE teachers and a whole lot of other skills that would be useful.

Ms. LYMAN. No; we really don't have people like that.

Mr. CHANDLER. Do they all die before they reach age 60?

Ms. LYMAN. No. We are an urban center located downtown in Baltimore and I think that our population reflects that of the city. I think you are much more inclined to find those out in the subur-

ban centers. We have some, but we also find that if they have done something and are in retirement, as a full-time profession they really don't want to do it in retirement.

Mr. CHANDLER. They don't need any busman's holidays.

But do you utilize the skills that you do have of seniors?

Ms. LYMAN. Oh, yes. As a matter of fact, our physical fitness coordinator that had this wonderful program I just described, just left to take a job in Virginia. And in that interim we find that the older people themselves are conducting those classes in aerobics and volleyball and jogging and swimming and all of that.

But I also want to say that it's a relatively new phenomenon in our experience that older people really are looking at prevention. It has always been kind of a joke that everybody believes in prevention once they are sick. But now they really do believe in prevention. They are taking steps to do something about it, women particularly in diet and nutrition counseling and men in exercise.

Thirty-five percent of our membership are men, which is fairly unusual for a senior center, and they are using the exercycle and swimming and all of that stuff.

Mr. CHANDLER. I think that is wonderful because there is no question in my mind if you keep your body active it will serve you well.

You also in your comments suggested, I think, that we don't need a new title but that you prefer expanding title IV. Perhaps you could comment a little more on that.

Ms. LYMAN. Only because in my knowledge of the senior center field, which is of course limited but fairly broad across the country, that much of this in one way or another is already started. It has not been done probably at the quality and the level of the educational instruction and the content that this bill would bring about, but because so much already exists, you know, it might be just plain easier to get it through as an additional title to the title IV than a new title of the Older Americans Act.

Mr. CHANDLER. It's your impression Federal money is now being used for some of those purposes outlined in this bill?

Ms. LYMAN. In a number of ways, not particularly to the value of senior centers. I think we have been fortunate in having the geriatric AHEC in Baltimore, but the funding for that, the Federal funding is over, and we are struggling for State funding and have not done as well as North Carolina has done with the State funding.

Mr. CHANDLER. But you are funded through the University of Maryland, which is primarly State funds, I assume.

Ms. LYMAN. But originally it was Federal funds under the public health services, and that has now run out, so that we are fighting at the State government level to continue the funds to the university. We may lose.

Mr. CHANDLER. Sure.

Thank you very much, Mr. Chairman, for the opportunity, and I want to congratulate you for the introduction of the bill and pledge my support in any way we can assist with this. I sure think you are on the right track.

Mr. ANDREWS. Thank you very much.

Let me apologize to everyone for my extreme tardiness. I called my daughter, who is in Chapel Hill, just before this meeting was to

begin and found that my mother they thought had had a heart attack last night and had died, in fact. But that turns out to be false, at least in the last respect, and probably in the first. I don't know what happened to her, but she is in the hospital there and lucid and apparently doing rather well.

I don't know what happened. I think I will leave after a while and go down, but I am sorry I was late for this.

As to the bill or new title, I think sometimes people who come up with something they think is a new idea, whether it is writing a book or whatever it is, tend to perceive that however they picture it it is the only way to do it. I hope I am not overly guilty of that.

But I think it is a good idea and I hope that we can stick to the original idea as much as is reasonable. I certainly don't want to be nonsubject to be persuaded otherwise.

One of the reasons I think the original idea—and I won't talk too long, though I am prone to do so—but one of the reasons I think the idea is a good one is not just that it benefits the elderly; it benefits the schools as well. The schools, whether in geriatrics or whatever are taught today, really have no adequate sort of laboratory wherein they can teach people to become teachers of health, especially for elderly people.

It is sort of like a field trip in botany. They don't have the actual place to do the practice teaching to become as good teachers as they might otherwise become. So, to permit them to be the teachers is not only I think to get graduate students who are being supervised by faculty and hence would probably be more competent than volunteers that might become accessible.

The senior citizens certainly have the motivation; but if they don't have the training I still question whether they have the breadth of experience. They may know a lot about aerobics, as you say, or swimming or something, but I doubt if they have the overall competence to deal with classes that may consist of 40, 50, 60 individuals.

Among them would be people who have a chronic spinal problem or certainly high blood pressure or all sundry other ailments that I think someone at least who is simply professional or quasi-professional, whatever the word might be, at least someone with that degree of competence would be a better instructor than an older person that only recently became interested in preventive health.

But I just feel like these graduate students, with the supervision of faculty, first of all, would be competent; second, they would receive course credit hopefully for this as somewhat of a laboratory experience.

I think they would do much more and a much better evaluation of what they have done to find out how they could next time do it better. I doubt that would be true—at least to that extent with the so-called volunteers, and so forth.

So I am not intransigent to change, but I am prone to try to stick with the idea, my original idea, as best we feel is plausible.

I know there are probably some areas where just geographically it is not plausible. There are areas in—particularly northern North Carolina—that are far removed from any institution of higher education, and in that case I would hope rather than volunteers we would use such things as county health officers, actual practition-

ers of medicine, nurses, and others who are trained. That is just my idea.

I appreciate your interest in it—your appearance here, certainly. I will look forward to reading your statements and thereby profiting from them.

Anyone else have anything for the good of the cause?

If not, again we thank you.

We will stand adjourned.

[Whereupon, at 11:30 a.m., the Subcommittee on Human Resources of the Committee on Education and Labor adjourned.]

37-680 O—84——10

APPENDIX

DEPUTY WHIP

COMMITTEES

CHAIRMAN SMALL BUSINESS COMMITTEE

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CHAIRMAN OF THE SUBCOMMITTEE ON SBA AND SBIC AUTHORITY, MINORITY ENTERPRISE AND GENERAL SMALL BUSINESS PROBLEMS

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SUBCOMMITTEES

HOUSING

JOINT ECONOMIC COMMITTEE

SUBCOMMITTEES

INVESTMENT, JOBS AND PRICES

TRADE, PRODUCTIVITY AND ECONOMIC GROWTH

PARREN J. MITCHELL
7TH DISTRICT, MARYLAND

Congress of the United States
House of Representatives
Washington, D.C. 20515

CONGRESSIONAL BLACK CAUCUS

CHAIRMAN OF THE SUBCOMMITTEE ON MINORITY ENTERPRISE, ECONOMIC DEVELOPMENT AND HOUSING

OFFICE OF CONGRESS

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FEB 10 1984

February 9, 1984

Honorable Ike Andrews
U.S. House of Representatives
Room 2201 R.H.O.B.
Washington, D.C. 20515

Dear Congressman ~~Andrews~~: Ike

First of all, let me express my strenuous support for your bill, H.R. 4472. This effort is sorely needed and I applaud your foresight. I deeply appreciate the invitation to review the initiative and offer my input.

I believe that the bill is quite workable and can render impeccable services at minimum cost. While we cannot put a price on the lives of our elderly, it is still essential that we provide the best services in the most cost-effective manner.

Since the new program will utilize graduate schools of public health and other such educational institutions, may I also suggest that it encourage the use of Holistic Health professionals. As you know, the holistic approach to health care has produced marked results in many cases and it would be quite innovative for educational classes to expose our elderly to this alternative. I believe these professionals will bring insight and be particularly helpful since the program will focus heavily on preventive health care instruction.

Again, I am very proud of this program and please make sure that my name is listed among the co-sponsors. Best of luck!

Sincerely,

Parren

Parren J. Mitchell
Member of Congress

PJM:ahp

(app 2 - 1 pp)

DEC 19 1983

JOHN P. EAST
NORTH CAROLINA

COMMITTEES:
JUDICIARY
ARMED SERVICES
LABOR AND HUMAN RESOURCES

United States Senate
Washington, D.C. 20510

December 15, 1983

The Honorable Ike Andrews
Member of Congress
United States House of Representatives
Washington, D. C. 20515

Dear Ike:

I thank you very much for your letter of December 2 and the attached information on H.R. 4472.

The points you make are certainly ture and are of major importance; our population is aging and will continue to do so for some decades, while older Americans (and all others as well) could significantly improve their health by adopting better habits.

I fully share your concern for finding an effective solution to this vital problem, and I applaud your efforts. I will be closely following the progress of H.R. 4472, and will be looking forward to your hearings on health education for older Americans.

Thank you again for letting me know of your initiative on this important matter; please keep in touch with me on this issue.

With best personal regards and wishing you a Merry Christmas, I am

Sincerely,

John

John P. East
United States Senator

JPE:pmh

DEC 12 1983

North Carolina General Assembly
House of Representatives
State Legislative Building
Raleigh 27611

REP FRANK REDDING
HOUSE DISTRICT 30—CHATHAM/RANDOLPH
HOME ADDRESS: BOX 330
ASHEBORO, N.C. 27203

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NATURAL AND ECONOMIC RESOURCES
WATER AND AIR RESOURCES

December 7, 1983

The Honorable Ike Andrews
U.S. Representative - 4th District
North Carolina
2201 Rayburn House Office Building
Washington, DC 20515

Dear Ike:

Thank you for sending me a copy of your news release about Health Education for Older Americans.

It appears that you have some good ideas and I hope they can be put to practical use without excess spending.

Sincerely,

Frank

Frank Redding

FR/sh

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November 23, 1983

Mr. Gordon Raley
Subcommittee on Health
2178 Rayburn House Office Building
Washington, DC 20515

Dear Mr. Raley:

Thank you for taking the time to talk with me on Monday, November 21, regarding H.R. 4472 and the Older Americans Act.

The American Dietetic Association is the largest organization of nutrition professionals, now 50,000 members strong. The Association considers elderly nutrition programs to be one of its highest priorities and has members working in all areas of geriatric nutrition including elderly feeding programs, home health care, hospice and nursing homes. An active gerontological dietary practice group is a vital component of the Association.

The ADA has been concerned with the reauthorization of the Older Americans Act since early 1983. The Association has been meeting with members of the White House Conference on Aging, the Administration on Aging, federal, state and local governments as well as private groups such as AARP to understand how the Act can best be revised to efficiently provide quality nutrition programs to elderly Americans.

LATHAM, WATKINS & HILLS

Mr. Gordon Raley
November 23, 1983
Page Two

We will be happy to forward any materials or recommendations we prepare to your office. We would also appreciate the opportunity to testify at a hearing, should one be scheduled by the subcommittee, on Title III of the Act.

If the Association can be of any assistance to you regarding this very important issue, please contact me. Thank you again for your time.

Very truly yours,

Cindy L. Witkin

Cindy L. Witkin, M.P.H., R.D.
Consultant to LATHAM, WATKINS & HILLS
Washington Counsel to the American Dietetic Association

NOV 29 1983

November 28, 1983

The Honorable Ike Andrews
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Andrews:

On behalf of all of the Deans of the Schools of Public Health in this country, in general and on behalf of Dr. Michel Ibrahim, Dean of the University of North Carolina School of Public Health, in particular, I want to applaud your efforts in seeking legislation to authorize the provision of health promotion and disease prevention services to the aging population. We stand ready to work with you in this most worthy endeavor.

As you can see by reviewing the enclosed testimony on S. 771 by our President, Dr. Bridgers, this Association has been advocating the delivery of prevention services for the last two years. We urge you to continue pursuing your idea.

Again, we are most willing to work with you and members of your staff. Please feel free to call on us at any time.

Sincerely,

Michael K. Gemmell
Executive Director

cc: Dean Ibrahim
Dean Bridgers
Deans, Schools of Public Health

Enclosure

mlc

ASPH
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PREPARED STATEMENT OF WILLIAM F. BRIDGERS, M.D., DEAN, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF ALABAMA IN BIRMINGHAM AND PRESIDENT OF THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH BEFORE THE COMMITTEE ON LABOR AND HUMAN RESOURCES, U.S. SENATE, S. 771

ASPH
ASSOCIATION OF
SCHOOLS OF
PUBLIC HEALTH
1015 FIFTEENTH ST., N.W.
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TESTIMONY OF THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH
TO THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES ON
S. 771 "HEALTH PROMOTION AND DISEASE PREVENTION AMENDMENTS
OF 1983," APRIL 25, 1983, WASHINGTON, DC

MR. CHAIRMAN, AND MEMBERS OF THE COMMITTEE, I AM WILLIAM BRIDGERS, M.D., DEAN OF THE SCHOOL OF PUBLIC HEALTH AT THE UNIVERSITY OF ALABAMA IN BIRMINGHAM AND PRESIDENT OF THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH, ON WHOSE BEHALF I AM APPEARING TODAY. THE ASSOCIATION APPRECIATES THE OPPORTUNITY TO TESTIFY ON BEHALF OF THIS LEGISLATION. WE STRONGLY SUPPORT IT AND APPLAUD YOUR AND SENATOR KENNEDY'S EFFORTS TO RECOGNIZE THE CONCEPT OF HEALTH PROMOTION AND DISEASE PREVENTION AS AN EFFECTIVE WAY TO CONTROL SKYROCKETING HEALTH CARE COSTS.

APPLICATIONS OF THE PRINCIPLES AND PRACTICE OF HEALTH PROMOTION AND DISEASE PREVENTION HAVE HAD DRAMATIC RESULTS IN RECENT MEMORY. THE NEAR ELIMINATION OF POLIO IN THE UNITED STATES AND OTHER INDUSTRIALIZED NATIONS, AND THE WORLDWIDE ERADICATION OF SMALLPOX ARE TWO RECENT EXAMPLES OF THE EFFECT OF PUBLIC HEALTH RESEARCH AND PRACTICE.

WITH THE CONTROL OF INFECTIOUS DISEASES, THE CHRONIC ILLNESSES ARE NOW OUR MAJOR CAUSES OF DEATH AND DISABILITY. HEART DISEASE, CANCER AND STROKE ARE CURRENTLY RESPONSIBLE FOR THE MAJORITY OF ALL DEATHS IN THE U.S. APPLICATION OF APPROACHES UNIQUE TO PUBLIC HEALTH, PROVEN SUCCESSFUL

IN CONTROLLING INFECTIOUS DISEASES, ARE VITAL IN THE EFFORT TO LIMIT THE TOLL FROM THESE CHRONIC AILMENTS.

PRESENTLY, HOWEVER, WE ARE SPENDING BILLIONS OF DOLLARS ON TREATMENT OF CHRONIC DISEASES AND RESEARCH TO FIND CURES FOR SUCH DISEASES, WHILE AT THE SAME TIME DEVOTING LITTLE OF OUR HEALTH CARE DOLLAR TO FINDING WAYS TO PREVENT CHRONIC DISEASES. IT IS ESTIMATED THAT TOTAL EXPENDITURES FOR PREVENTIVE SERVICES IN THE EARLY 1970S AMOUNTED TO 2 to 2.5 PERCENT OF OUR TOTAL HEALTH CARE BILL; FOR HEALTH EDUCATION, PROBABLY LESS THAN ONE-HALF OF 1 PERCENT. DESPITE THE RENEWED FOCUS ON PREVENTION IN HHS, CURRENT ESTIMATES OF THE PERCENT OF OUR HEALTH CARE DOLLAR SPENT ON PREVENTION ARE AT ABOUT THE SAME LEVEL AS IN THE EARLY 1970S. EXCEPT FOR THIS BILL, MR. CHAIRMAN, THERE IS LITTLE EVIDENCE TO INDICATE ANY REAL FEDERAL COMMITMENT TO INCREASING FEDERAL SUPPORT FOR PREVENTION.

TO JUSTIFY PRESENT FUNDING LEVELS FOR PREVENTION RESEARCH, SOME ARGUE (WITH CONSIDERABLE JUSTIFICATION) THAT ALL NIH AND ADAMHA BASIC RESEARCH ON LIFE PROCESSES AND/OR DISEASE CAUSES IS PREVENTION. YET WE IN ACADEMIC PUBLIC HEALTH DEFINE PREVENTION AS:

- INVESTIGATIONS INTO THE EPIDEMIOLOGY OF DISEASE;
- RESEARCH ON IMMUNIZATION STRATEGIES
- STUDIES OF THE ONSET OF DISEASE AS AFFECTED BY DIET AND OTHER PERSONAL HABITS AND BY ENVIRONMENTAL FACTORS
- STUDIES OF THE MEANS TO PRECLUDE THE DEVELOPMENT OF DISEASE, OR THE POSTPONEMENT OF ITS SYMPTOMATIC ONSET, THROUGH CHANGES IN PERSONAL HABITS AND ENVIRONMENTAL FACTORS
- STUDIES OF METHODS FOR AND THE COST-EFFECTIVENESS OF POPULATION SCREENING PROGRAMS

PREVENTION'S RECORD IN THE PAST IS IMPRESSIVE BUT MORE NEEDS TO BE DONE. IN ORDER TO EXPLOIT FULLY THE POWER OF THE PREVENTIVE APPROACH, FURTHER INVESTIGATIVE AND EDUCATIONAL WORK MUST BE CARRIED OUT. TO THIS END, IT IS RECOMMENDED THAT THE CONGRESS COMMENCE A SERIES OF STEPS THAT WOULD LEAD TO THE ESTABLISHMENT OF A NETWORK OF CENTERS FOR RESEARCH AND DEMONSTRATION ON HEALTH PROMOTION AND DISEASE PREVENTION AT SOME OF THE NATION'S OUTSTANDING ACADEMIC HEALTH CENTERS. YOUR BILL, MR. CHAIRMAN, PROPOSES THE CREATION OF SUCH CENTERS. THESE CENTERS WILL CONDUCT RESEARCH ON WAYS OF PROMOTING POSITIVE HEALTH AND PREVENTING ILLNESS. FURTHERMORE, THE CENTERS WILL COLLECT INFORMATION AND RESEARCH FINDINGS AND TRANSLATE THEM INTO PRACTICE THROUGH TECHNICAL ASSISTANCE, EDUCATION AND THE PROVISION OF PUBLIC INFORMATION TO GROUPS, COMMUNITIES AND GOVERNMENTAL AGENCIES.

THE PRINCIPAL ATTRIBUTE OF EACH CENTER WOULD BE ITS CAPABILITY TO CARRY OUT RESEARCH IN DISEASE PREVENTION AND HEALTH PROMOTION: ITS PHYSICAL RESOURCES AND STAFFING MUST BE ADEQUATE FOR BOTH SMALL, SINGLE INVESTIGATOR-INITIATED STUDIES AND LARGE, MULTIINSTITUTIONAL AND MULTIDISCIPLINARY COOPERATIVE PROJECTS. IN MOST CASES, MEETING THIS CRITERION MIGHT REQUIRE IN PLACE A WORKING RELATIONSHIP WITH RELEVANT GROUPS, SUCH AS CLINICAL INVESTIGATORS, SCHOOLS OF NURSING, PSYCHOLOGY, BUSINESS, LAW OR ENGINEERING. IN ALL CASES, IT WOULD REQUIRE STRONG CAPABILITIES IN DEALING WITH STUDIES OF POPULATIONS OVER TIME, INCLUDING THOSE KNOWLEDGEABLE IN STATISTICAL AND EPIDEMIOLOGICAL METHODOLOGY. THE ESSENTIAL ATTRIBUTE THAT WOULD TRANSCEND ALL OTHERS WOULD BE THAT A CENTER HAVE DEFINED POPULATIONS UNDER OBSERVATION.

DESIRABLE ATTRIBUTES WOULD BE ACTIVE GRADUATE TRAINING PROGRAMS IN THE AREAS RELEVANT TO DISEASE PREVENTION AND HEALTH PROMOTION STRATEGIES. ANOTHER DESIRABLE ATTRIBUTE WOULD BE "CLINICAL" ACTIVITIES: SERVICES TO INDIVIDUALS AND TO GROUPS WHO WISH TO IMPROVE THEIR FUNCTIONING AND TAKE STEPS TO AVOID ILLNESS. THESE ACTIVITIES SHOULD BE DISPENSED LARGELY, IF NOT ENTIRELY, ON

A FEE-FOR-SERVICE BASIS, AND THIS SOURCE OF FUNDS SHOULD, OVER TIME, CONSTITUTE A SIGNIFICANT PROPORTION OF THE FINANCIAL SUPPORT OF CENTERS. IT SHOULD BE NOTED THAT THE PRACTICES OF THIRD PARTY PAYORS DO NOT PRESENTLY PERMIT REIMBURSEMENT FOR THESE TYPES OF SERVICES, BUT THESE ARE EXPECTED AND SHOULD BE ENCOURAGED TO CHANGE. THESE CHANGES, IN TURN, WOULD SERVE AS A STRONG INCENTIVE TO THE CENTERS TO EXPAND SUCH CLINICAL ACTIVITIES.

WE NOT ONLY SUPPORT THE BILL'S SECTION AUTHORIZING CENTERS FOR RESEARCH AND DEMONSTRATION ON HEALTH PROMOTION AND DISEASE PREVENTION, WE ALSO STRONGLY ENDORSE THE FOLLOWING PROVISIONS OF S. 771:

- THE ESTABLISHMENT OF AN OFFICE OF HEALTH PROMOTION IN OASH
- THE SUBMISSION OF AN ANNUAL REPORT TO CONGRESS ON ALL DEPARTMENT ACTIVITIES RELATING TO PREVENTIVE MEDICINE AND HEALTH PROMOTION
- THE CREATION OF AN ASSISTANT DIRECTOR FOR PREVENTION IN NIH TO OVERSEE NIH PREVENTION RESEARCH PROGRAMS AND COORDINATE THESE PROGRAMS WITH OTHER HHS ACTIVITIES

WE SEE THESE AS IMPORTANT STEPS IN THE EVOLUTION OF THE PREVENTION INITIATIVE IN HHS. WE WISH THE EVOLUTION COULD BE EVEN FASTER, AND THAT IT WAS POSSIBLE TO ESTABLISH A NEW INSTITUTE: A NATIONAL INSTITUTE FOR HEALTH PRESERVATION, OR SOME COMPARABLE TITLE. HOWEVER, WE ARE COGNIZANT OF THE DIFFICULTIES OF ADOPTING, AT THIS TIME, ANY MAJOR ORGANIZATIONAL INITIATIVE MUCH BEYOND THOSE PROPOSED IN THIS LEGISLATION. ALTHOUGH THE TITLE "NIH" IMPLIES A FOCUS UPON HEALTH, THE SEVERAL SEPARATE INSTITUTES FOR THE MOST PART EMPHASIZE DISEASES INSTEAD. WHEREAS WE DO NOT MEAN TO IMPLY THAT THESE FOCI ARE INAPPROPRIATE, WE SEE CONSIDERABLE MERIT IN GIVING THE CONCEPT OF HEALTH EQUAL TIME, AS IT WERE, ALONG WITH EQUAL VISIBILITY.

WE ALSO WISH TO COMMENT ON THE IMPORTANCE OF COOPERATION BETWEEN NIH AND OTHER AGENCIES WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, NOTING SPECIFICALLY THE CENTERS FOR DISEASE CONTROL. THAT ENTITY OBVIOUSLY

HAS BEEN A LEADER IN PREVENTION EFFORTS TO DATE AND THE RESEARCH STUDIES REQUIRED MIGHT, IN MANY INSTANCES, FALL WITHIN THE EXPERTISE OF THE CDC STAFF AND THEIR COLLEAGUES

FINALLY, WE WISH TO SUPPORT THE PROVISION IN THE BILL THAT PROVIDES "ENROLLMENT RELIEF" TO VARIOUS SCHOOLS OF PUBLIC HEALTH THAT HAVE FALLEN SHORT OF REQUIRED STUDENT CLASS SIZE LEVELS. THEY MADE GOOD FAITH EFFORTS TO ENROLL THE REQUIRED NEW, FULL-TIME STUDENTS FOR THE FALL OF 1982, BUT HAVE BEEN ADVERSELY AFFECTED BY FACTORS BEYOND THEIR CONTROL. FURTHER EFFORTS WOULD HAVE JEOPARDIZED THE QUALITY OF THEIR EDUCATIONAL PROGRAMS AND THEREFORE WE ARE REQUESTING CONGRESS TO AMEND SECTION 771 (a) (2) AND (e) OF THE PHS ACT TO WAIVE ENROLLMENT AND MAINTENANCE OF NON-FEDERAL SUPPORT REQUIREMENTS ON THE BASIS OF ENDANGERING ACADEMIC QUALITY.

TOTAL STUDENT ENROLLMENT, MR. CHAIRMAN, HAS NOT DECLINED --- JUST FIRST YEAR, FULL-TIME ENROLLMENT. THE FACTS ARE THAT THE ECONOMY HAS DRASTICALLY CHANGED SINCE THE REQUIREMENT WAS ENACTED AND MORE OF OUR STUDENTS CONTINUE THEIR EMPLOYMENT WHILE PURSUING THEIR STUDIES AND THEREFORE ARE PART-TIME STUDENTS; FURTHERMORE, MORE OF OUR STUDENTS ARE MID-CAREER PROFESSIONALS WITH FAMILIES TO SUPPORT AND CANNOT AFFORD TO BE FULL-TIME STUDENTS.

THUS WE ARE IN FACT ACHIEVING THE OBJECTIVE OF THE ACT BY TRAINING MORE PUBLIC HEALTH PROFESSIONALS THAN IN FORMER YEARS, BUT THE MAJORITY OF OUR STUDENTS TODAY CANNOT BE COUNTED ACCORDING TO THE LAW. WE EXPECT THIS TREND TO CONTINUE. THE DIFFERENCE BETWEEN THE REQUIREMENT OF THE LAW AND EDUCATIONAL TRENDS WILL BECOME MORE DISPARATE.

IN SUMMARY, THE SCHOOLS OF PUBLIC HEALTH HAVE MADE EVERY REASONABLE EFFORT, WHILE GUARDING PROGRAM QUALITY, TO MEET THEIR CAPITATION TARGETS. THE FORCES WORKING AGAINST THOSE EFFORTS, PREDOMINANTLY ECONOMIC, ARE BEYOND THEIR CONTROL.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, WE URGE YOU TO ADOPT S. 771 AS WRITTEN AND APPLAUD YOUR FORESIGHT IN HOLDING HEARINGS ON A BILL THAT EMPHASIZES DISEASE PREVENTION, HEALTH PROMOTION, COST CONTAINMENT AND SUPPORT FOR SCIENTIFICALLY BASED PREVENTION RESEARCH. THESE GOALS WILL NOT ONLY SAVE LIVES AND IMPROVE THE QUALITY OF LIFE, BUT ALSO SAVE MONEY IN THE FORESEEABLE FUTURE. WE THANK THE MEMBERS FOR GIVING US THE OPPORTUNITY TO COMMENT AND SUPPORT THIS PREVENTION BILL. WE ARE MOST WILLING TO WORK WITH YOU AND WITH YOUR STAFF IN SEEKING ENACTMENT OF S. 771. THANK YOU.

I WILL BE HONORED TO ANSWER ANY QUESTIONS.

1/84

Association of Schools of Public Health

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(202) 842-4668

HR 2350
&
S 771

ASPH Centers Fact Sheet
Contact: Michael K. Gemmell

CENTERS FOR RESEARCH AND DEMONSTRATION ON HEALTH PROMOTION AND DISEASE PREVENTION

PURPOSE: The Association of Schools of Public Health (ASPH) requests Congress to authorize a network of Centers for Research and Demonstration on Health Promotion and Disease Prevention that will complement the Centers for Disease Control and other federal initiatives in health promotion and disease prevention.

OBJECTIVE: The Surgeon General's Reports on "Healthy People" (1979) and "Promoting Health/Preventing Disease, Objectives for the Nation" (Fall, 1980) clearly stress the importance of preventing illness as an essential facet of a cost-effective health services system. What is needed is a major expansion in research to focus on ways of promoting health and on improved methods of appraising health hazards and risk factors. Centers can also serve as demonstration sites for translating new knowledge into practice and in other ways by disseminating information on findings.

REASON: Public health and preventive medicine have had outstanding successes in the past in sanitation, nutrition, immunizations, and maternal and child health through the local and state health departments but a new approach is required for studies of health behaviors, personal lifestyles, and societal and self-imposed risks of stress, and methods of coping. A federal network of centers has been the proven pattern of expanding research and demonstration projects in cancer research and control, cardiovascular disease, and other categorical conditions. The same approach is not needed in health promotion.

CHARACTERISTICS OF A CENTER: The principal attribute of each Center is its capability to carry out both research and demonstration projects in disease prevention and health promotion. Each should be located in an academic health center with a multidisciplinary faculty and have demonstrated working relationships with other relevant groups in medicine, psychology, nursing, social work, education, business, etc. There should be graduate training programs relevant to disease prevention and research on retrospective and longitudinally prospective bases in population groups and communities in collaboration with local authorities or

industrial resources. The core faculty must be especially strong in epidemiology, biostatistics, and the social sciences and have immediate access to biomedical colleagues. The Center must be prepared and qualified to evaluate and to enhance its performance over time.

In addition to research, the Center, in cooperation with the Centers for Disease Control, is expected to undertake demonstration projects that will translate and apply research findings in the community. Using, as appropriate, community outreach and organization techniques, as well as other methods of educating and motivating groups and communities, each Center is to provide health promotion and disease prevention consultative services to defined population groups. Most importantly, each Center must demonstrate the capability of providing technical assistance to public health agencies in the community.

NUMBER OF CENTERS: The network should consist of approximately 25 Centers. The Centers would be distributed geographically, would work with different ethnic groups and urban-rural populations, and would deal with a wide range of medical interests, including cancer, cardiovascular diseases, mental hygiene and accidents.

LOCATION OF CENTERS: As indicated, an academic health center is essential. This would include Schools of Public Health and many departments of preventive medicine in the nation's medical schools.

FUNDING: The federal funding of $1 million per year should provide for core faculty and administrative support. For the nation, an initial round of ten Centers should be established, with an additional ten the second year and five more the third year. The Congress should authorize $10 million in year one, $20 million in year two and $25 million in year three. This core support should be scheduled for not less than five years per Center. Funding for individual research and other special projects would remain on a competitive basis through the usual channels of peer review.

STARTING DATE: It is urged that Congress appropriate funds for the Centers through the Fiscal Year 1984 supplemental appropriations bill. This will enable the establishment of several Centers around October 1, 1984.

DEC 12 1983

Rt. 2 Box 52
Siler City, N.C.
Dec. 1, 1983

Congressman
Ike Andrews
Dear Sir:

In Reply to the wonderful Information I received today, Concerning the wonderful work You are doing for the Elderly, Thank You Very Much.
I Carried it to the Multi-purpose Center, And every word was read before we had our lunch, And Your wonderful work was well Accepted by the members And they do appreciate what You are doing for Health Education And for Older Americans

thank You thank You thank You Very Much

Sincerely
Mattie Page

PS: My Letter Came back I am mailing it again

DEC 7 - 1983

RETIRED SENIOR VOLUNTEER PROGRAM
SPONSORED BY VOLUNTARY ACTION CENTER

1520 Aberdeen Road
Telephone 804, 827-7722
HAMPTON, VIRGINIA 23666

December 2, 1983

U.S. Representative Ike Andrews
2201 Rayburn HOB
Washington, DC 20515

Dear Mr. Andrews,

Thank you for your letter on your health concerns for the elderly.

Some courses in nutrition were long ago introduced in senior centers under supervision of area offices on aging. Exercises are also taught in these centers as well as home use of sanitation procedures and germicides.

Your intentions are excellent and your bills to cope with a mind-boggling problem are a step in the right direction,but real nutrition, real side effects of prescription medicine and real treatment of cause of disease is avoided in our country. Our doctors treat symptoms; our T.V. ads sell billions to treat symptoms; our populace thinks in terms of relief of symptoms.

T.V. should be your medium, for older people are forever in front of T.V. At present the drivel from doctors on health advice specials is a detriment to the profession. Doctors give patients medicines without even checking their histories as to what they already take, then cry that patients mix medicines.

It is the ignorance about nutrition of the medical profession and the public health advisors which must be addressed. When this is changed the health of the public will change.

Nutrition needs to be taught to the whole population. Worst of all diets are now that of our young people. The results will be there when they are old.

37-680 O—84——11

Our nursing homes, schools, hospitals, meals on wheels programs and almost every feeding program in America serve mainly canned foods, colored gelatins, dessert mixes and colored artificial punch. The instructions from public health do not describe the American dilemma of poor health arising from general use of poor foods such as these. The additional problems of poisonous chemicals we are eating and drinking are going to continue to keep this country in lower health levels compared to the world's major nations.

Education in nutrition and control of too much medicine must start in the government.

Yours,

Virginia H. Rollings

Virginia H. Rollings
RSVP Director

lv

DEC 7 - 1983

3702 Turrentine Street,
Durham, N. C. 27705

Dec 3, 1983

Hon. Ike Andrews,
2201 Rayburn Bldg.,
Washington, D. C. 20515

Dear Mr. Andrews:

I have received a copy of your proposal for Health for Older Americans. I hasten to address yourproposal and make some comments.

For seven years I worked as an accountant and fiscal officer for the Coordinating Council for Senior Citizens in Durham I was specifically employed to do accounting and other office duties for the Senior Aide Employment Program. In thepeak years we had as many as 80 senior citizens as part time employees. They were, for the most part, covered by Medicare health insurance as well as supplemental health insurance which was provided under a contract between the National Council of Senior Citizens and the Sentry Insurance Company at no cost to the individual Senior Aide except a small members dues to the NCSC. My experience of 7½ years with individual and attendant insurance problems has provided me with some conclusions.

1. Some individual doctors and allied services take advantage of the Medicare program.

2. Some participants in the programs also take advantage of it.

3. The paper work and procedure is too complex in processing claims for a great number of participants to understand.

4. Most of these people need individual and personal assistance with their Medicare and insurance claims.

5. Medicare instruction even by the most qualified in a classroom will go in one ear and out the other.

6. An organization, such as you suggest, will be costly for it will not only involve fees for instruction but also travel, work shops, etc.

My suggestion is that each Senior Center has a staff member properly instructed and qualified to give individual assistance to Senior citizens in their area.

I realize that there are many in 35 million who are quite capable of handling their own health insurance problems, but my experience that the vast majority are not.

Sincerely yours,
W. H. Guthrie

EAST CAROLINA UNIVERSITY
GREENVILLE, NORTH CAROLINA 27834

SCHOOL OF
ALLIED HEALTH AND SOCIAL PROFESSIONS
TELEPHONE 919-757-6961

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December 5, 1983

The Honorable Ike Andrews
121 Edinburgh South
Suite 205
Cary, North Carolina 27511

Dear Congressman Andrews:

Dr. Don Ensley, a colleague here in the Department of Community Health, has shared with me a recent article on your proposal to amend the 1965 Older American Act to add health education services.

First, I want to commend you and thank you for this needed initiative. Having worked with public health, mental health and centers for senior citizens, I am very much aware of the need for strong health education components for their clients.

For several years here, I served as Associate Dean of the School of Allied Health, devoting most of my energies to assisting poor, elderly and often rural areas in developing various health care plans and projects. For several years, I headed our Office for Community Health Services, which provided consultation and technical assistance to numerous communities.

Unfortunately, the elderly and the poor have suffered some setbacks, as have our own budgets. In fact that very effective Office for Community Health Service was dismantled.

With the effect of DRG rules upon hospitals, plus a freeze on the number of nursing home beds in North Carolina, it is increasingly important that we enable elderly people to be healthy, safe and secure in their own homes, or homes of relatives. In this connection, we have done some limited investigation of the potential benefit of educational programs on residential accident prevention, and the benefit of "environmental audits" of residences of the elderly, to help prevent accidents, disability or death. Education about drug interactions, self help, etc. are also needed services.

The Honorable Ike Andrews
December 5, 1983
Page 2

We are positioned professionally and staffed appropriately to provide useful support and leadership in the direction you have so properly charted. We would appreciate the opportunity to work with you and your staff in every way possible to bring your ideas to fruition.

Sincerely yours,

William Carlton Byrd, Sr.
Professor of Community Health

WCB/gh
cc: Congressman Walter B. Jones
Dr. Donald Ensley

DEC 12 1983

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL
27514

OFFICE OF THE CHANCELLOR

103 SOUTH BUILDING 005A
(919) 962-1365

December 6, 1983

The Honorable Ike Andrews
House of Representatives
Congress of the United States
2201 Rayburn House Office Building
Washington, DC 20515

Dear Ike:

Many thanks for your letter of November 29 and the interesting attached statement and Bill. I am glad to see you taking this leadership in an area of unknown potential, and you may count on the University's health schools to do all they can to assist in this region of the country.

With appreciation and best wishes,

Sincerely yours,

Christopher C. Fordham, III

DEC 9 1983

12-6-83

Dear Representative Andrews,

I would like to voice my support for your proposed health education program for the elderly.

This is a program which is long overdue. I feel especially concerned that older Americans are warned about "quack" medicines & cures. My mother suffers from rheumatoid arthritis and is often barraged with "helpful" friends and their homegrown remedies.

Your proposal makes me very glad I voted for you!

Sincerely
Sharon Whitlock MT (ASCP)

Sharon Whitlock
6905 Holly Dr
Raleigh, NC 27609

DEC 7 - 1983

December 6, 1983

The Honorable Ike Andrews
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Again, on behalf of all the Deans of the Schools of Public Health, we congratulate you for introducing H.R. 4472, a bill authorizing the provision of health promotion and disease prevention services to our Nation's senior citizens. We think it to be a very appropriate and well-timed campaign designed to help them maintain proper health status.

As an example of the kinds of projects envisioned by your bill, I'm sending you a press release describing a project conducted by graduate students and a faculty member from the Berkeley School of Public Health. It outlines what can be accomplished by utilizing the unique resources available in our Schools.

Sincerely,

Michael K. Gemmell
Executive Director

Enclosure

cc: Dean Ibrahim
Dean Lashof

nlc

ASPH
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1015 FIFTEENTH ST. N.W.
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WASHINGTON, D.C. 20005
202-842-4668

Release based on paper
to be presented at
36th Annual Meeting of
the Gerontological Society
of America...panel on "New
Perspectives on Elderly
Support Networks"...
1:30-3:30 p.m. Sunday 11/20/83
...Continental Room 5/San Francisco
Hilton Hotel

OFFICE OF PUBLIC INFORMATION

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11/18/83--Splatter--File #8852

FOR IMMEDIATE RELEASE

Berkeley--An unusual program called the Tenderloin Senior Outreach Project (TSOP) in the heart of San Francisco's high-crime Tenderloin District is paying off in safety and health benefits for many of the city's elderly.

The project, started by three graduate students and their professor from the University of California's School of Public Health in Berkeley, now involves residents of eight Tenderloin hotel participating in weekly support groups -- still a small percentage of the 8,000 elderly in the area.

Although specific results are hard to measure, the founders report that the program has influenced such developments as:

--a 26 per cent drop in crime during the last year, which police have attributed in part to the program.

--help from 48 businesses, bars and restaurants that act as safehouses, where community residents can turn during an emergency.

--a mini-market set up every week to offer low-cost fruits and vegetables to the elderly.

--"immeasurable" gains in self-esteem and innumerable friendships for those in the program.

The successes of TSOP are reported in a paper prepared for delivery Sunday (Nov. 20) by Meredith Minkler, associate professor of public health at U.C.-Berkeley, during the 36th Annual Meeting of the Gerontological Society of America in San Francisco.

-more-

In 1977, Minkler approved a class project in which three graduate students from U.C.'s School of Public Health went to the lobby of a Tenderloin hotel one morning each week and offered free blood pressure screenings.

The idea was to allow the students to meet with the residents and to encourage conversation among them on community issues.

According to Dennis Stone, who was then director of the North of the Market Medical Clinic, some 20 percent of the elders in the Tenderloin never or rarely left their rooms.

Gradually, as the levels of trust improved, the U.C. students suggested that the residents meet informally on a regular weekly basis. Within two years, support groups had been started in other Tenderloin hotels.

In 1979, with the help of a grant from the Levi-Strauss Foundation, the project gained momentum when doctoral student Sheryl Frantz organized weekly support groups in five Tenderloin hotels.

Nearly a hundred students, mostly from U.C.-Berkeley, U.C.-San Francisco and San Francisco State University -- joined Frantz in helping residents from their support groups and work on community action projects.

A survey conducted in this area by Minkler of 216 elderly persons revealed a high rate of social isolation.

Twenty-five percent of those surveyed indicated that they experienced no contact with close friends or relatives for that month.

Minkler is among a growing number of health and social scientists who believe that friendship and strong social ties are related to physical and mental health.

Subtle signs showed that these necessary kinds of social networks

were increasing as a result of the project, Minkler said.

For example, when one resident in a support group was hospitalized for a combination of diabetes, hypertension and heavy drinking, he was visited in the hospital by another member of the group. He later commented, "That was the first time since I was a child that anyone visited me in the hospital. I had no idea that anyone in this hotel cared, and I'm going to cut down on my drinking."

By 1981, the elderly had formed an inter-hotel coalition: Tenderloin Tenants for Safer Streets. They requested to meet with the mayor and chief of police.

Mayor Dianne Feinstein was so impressed with the organization that she canceled an entire week's agenda in order to spend each morning of the week with the groups in their hotels, Minkler noted in her report.

In response to the residents' recommendations, Feinstein increased the number of beat patrol officers in the area and asked that they stop into hotels each morning before going on duty.

The safehouse idea became the next priority item. And now the focus is on improving nutrition in the Tenderloin. In addition to the mini-market, efforts are under way to develop co-operative food purchasing programs for the community, Minkler said.

In April 1982, TSOP became a non-profit organization with half of its board of directors residents from the Tenderloin.

Under current project director, Robin Wechsler, TSOP has received grants to develop a health promotion resource center for seniors and a special program to encourage leadership among the elderly.

Of greatest importance, in Minkler's view, is the fact that the elderly residents are taking responsibility for changing their environment and they are lifting their own morale.

####

Professor Minkler can be reached at 642-4397 or 644-3452 (on Sunday 11/20 via conference office of the Gerontological Society of America at the San Francisco Hilton)

DEC 12 1983

LAW OFFICES
MORGAN, BRYAN, JONES & JOHNSON
101 E. FRONT STREET
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December 6, 1983

The Honorable Ike Andrews
U.S. House of Representatives
Washington, D.C. 20515

Dear Ike:

Your plan to provide medical education for the elderly is long overdue.

I run into so many elderly people suffering with depression much of which is brought on by lack of proper diet and exercise. This is brought on to a large degree by a lack of understanding.

We are involved now in the estate of an elderly lady who became mildly depressed, lost her appetite, failed to realize the value of a proper diet and proper eating. The less she ate the more depressed she became and she finally died of starvation.

Sometimes I think that before a person is eligible for medicare he or she should have to complete some kind of medical education course and remained signed up in an exercise program such as walking or anything to keep them physically active. It really is not right for a person to refuse to do any thing to help their own physical condition and run up high medical bills which would be unnecessary, or much of which would be unnecessary, if they cared for themselves properly. So much of this, and perhaps most of it, comes from a lack of understanding.

MORGAN, BRYAN, JONES & JOHNSON

The Honorable Ike Andrews
December 6, 1983
Page 2

Good luck on your program and congratulations for coming up with it.

Sincerely yours,

Robert

Robert B. Morgan

RBM/wdi

P. S. Dear Congressman:

After typing Mr. Morgan's letter, I just wanted to add a few of my thoughts. As a psychology major, I am frequently studying the elderly population. I guess one of my main concerns is the increasing number of people over 65. By the year 2013 our population will consist of between 20-25% of people over 65. This percentage will be brought out by the baby boom of WWII of which I am one of those. This concerns me now, not in the year 2013 when I will be in that percentage.

A few nursing homes are now implementing activities programs and other special-type programs for the elderly to keep them involved and active. I think this is a major step in the right direction.

Our society thrives on youth, but we fail to realize that our elderly are becoming more and more a greater percentage of our population.

I wholeheartedly support your plan for the elderly

Judy Breeden

Judy Breeden
Secretary to Mr. Morgan

12/6/83

Honorable Dan Quayle
2201 Dirksen Building
Office Building
Washington, D.C. 20515

Dear Sen. Dan Quayle

I have been apprised of your Bill HR #4472 by Burr Pruitt, and I am in full support of Health Education for the Elder Americans.

I am in complete agreement with the testimony rendered by John Rother, Staff Director & Chief Counsel to Sen. Heinz. where it was reported out aid of committee on Aging for the Senate and released as a document from the Gov. Printing Office 1983.

It addresses ten (10) fraudulent schemes directed toward the Elderly. Five of them or 50% of the topics of fraudulent schemes are directly related to Health Education.

I am a member of West Chester University in Penna where we are currently testifying in Harrisburg and I am sure we need the passage of your Bill it would eventually aid 11% to 12% of our 65+ population.

I have attained an Ed. S. (Education Specialist) degree from the Univ. of Michigan and believe that my thirty-three (33) years of experience in the Educational Processes permits me to say that School Health Educators are qualified to carry-out the mission.

I would like to see the opportunity opened up to School Health Educators as well as Public Health Educators. We, the schools, have the facilities, the expertise, the trained personnel as well as the knowledge. All we lack is the financing. With HB 4472 we can and will carry-out Health Education for the Elderly that will extend, enrich, and give meaning to older (our) american lives.

Yes, I support HB 4472 and would appreciate any support that you can "bring to bear" that will provide Health Education for the Elderly be approved by those institutions offering School Health as well as Public Health Certification.

Thank you

John DeMellion - Hlth Dept.
West Chester University
West Chester, Pa 19383

DEC 1983

UNIVERSITY OF CALIFORNIA, BERKELEY

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SCHOOL OF PUBLIC HEALTH
DEPARTMENT OF SOCIAL AND
ADMINISTRATIVE HEALTH SCIENCES

BERKELEY, CALIFORNIA 94720

December 8, 1983

U.S. Representative Ike Andrews
2201 Rayburn House Office Bldg.
Washington, D.C. 20515

Dear Congressman Andrews:

I am writing to express my very strong support for your bill, HR 4472 which would establish a new title to the Older Americans Act adding health education and training to the services already provided to elders through the OAA's multipurpose senior centers.

As a professor of public health, a former chairperson of the health education section of APHA and an American deeply concerned about the needs of this nation's "fastest growing minority", I am convinced that your bill represents an intelligent, humane and cost effective means of addressing the critical need for effective health education among many of America's elders.

HR 4472 is firmly grounded in several fundamental health education principles in its appreciation of "face to face" versus more indirect mass communications approaches and in its concern with bringing educational programs to the people, at more than 3,000 senior centers around the country, rather than expecting the people to come to them.

Yet the bill has another critical health education and training component which is not spelled out directly and yet which, in the long run, may constitute one of its most valuable benefits.

I refer to the profound influence which enactment and implementation of this bill may have on geriatric and gerontological health manpower development, research and training through its conscious involvement of faculty and students in the nation's graduate schools of public health.

While public health professionals have become increasingly concerned with the health needs of America's 25 million elderly (as exemplified, for example, in the genesis and dramatic growth of APHA's Gerontological Health Section) many public health students and faculty--like their medical school counterparts--take little interest in the field of aging. Unfortunately, public health professionals have no natural immunity to gerontophobia or the cultural dread of aging so pervasive in American society. As a consequence, many students of public health don't stop to consider a career oriented toward helping to meet the health needs of the nation's elderly.

Representative Ike Andrews

December 8, 1983

The connecting of schools of public health with the OAA's multipurpose senior centers so that faculty and students become providers of health education through the centers, may in fact have at least as great an educational "pay off" for public health professionals as it does for the elders they serve. By putting potentially thousands of graduate students and faculty in contact with older Americans, the program is bound to help break down myths, prejudices and sterotypes about the elderly while increasing student and faculty interest in and commitment to working--perhaps on a career basis--toward better meeting the needs of this rapidly growing population group.

I commend you on a bill which represents a well conceptualized and cost effective approach to a major public health need, and will be happy to provide whatever additional support I can toward the end of helping to insure its passage.

Sincerely yours,

Meredith Minkler

Meredith Minkler, Dr.P.H.
Associate Professor & Chair

MM:sa
cc: Dean Lashof
Wendy Squyres

37-680 O—84——12

DEC 13 1983

BALL STATE UNIVERSITY MUNCIE, INDIANA 47306

COLLEGE OF SCIENCES & HUMANITIES
Department of Physiology and Health Science

December 9, 1983

Honorable Ike Andrews
Representative, North Carolina
2201 Rayburn HOB
Washington, D.C. 20515

Dear Representative Andrews:

I have recently been informed by Buss Pruitt, Executive Director, Association for the Advancement of Health Education, Reston of your proposed legislation HR 4472 - Older Americans Personal Welfare, Education and Training Program. I laud your introduction of this much needed legislation for a too, often neglected segment of our society. It is my feeling that this legislation may not only have the desired effect of health promotion and individual responsibility for health within the target group but equally important may be a serendipitous result of a positive impact on the "out of control" spiraling of health care costs. I support the desirability of and need for this proposed program and stand ready to assist in any way that I can. I am sending a copy of this letter to my representative, Phil Sharp, in the hope that he will choose to co-sponsor if such assistance is needed.

One concern that I have, as I understand your bill, is that you restrict the training to schools of public health. I'm well aware of the excellent job in the preparation of health educators that some of these schools are doing. Still, I want to alert you that there are many other institutions, some in North Carolina, which are preparing health educators but not under a "school of public health" administrative structure. Many of these institutions are also graduating students who are well prepared to carry out health education activities with the elderly. I make my point by sharing the fact that a recent study at the University of Illinois showed my university, Ball State, to have the most outstanding master's level program in health education in the nation - a study conducted among peers in the profession. This is to say that we feel that our graduates have the background, ability and desire to work with the elderly, their health and illness problems. I feel as if my colleagues at East Carolina University and the University of North Carolina-Greensboro, institutions with programs similar to ours, would feel the same way.

The most important thing, however, is the need for such legislation - a need expected to grow as our elderly population continues to grow in size. I admire your foresight in seeing the need and having the courage and insight to propose a solution. Thank you!!!

Sincerely,

Herbert L. Jones
Professor, Health Education

Ball State University is an equal opportunity employer

DEC 15 1983

STATE ADVISORY COUNCIL ON EDUCATION
330 NORTH WILMINGTON STREET
WATSON HOUSE
RALEIGH NORTH CAROLINA 27604
(919) 733-2064

THOMAS S. BRIGHTON
CHAIRMAN

E. MICHAEL LATTA
EXECUTIVE DIRECTOR

December 12, 1983

Congressman Ike Andrews
U.S. House of Representatives
2446 Rayburn Building
Washington, DC 20515

Dear Congressman Andrews:

Thank you for sharing with me your recent statement on Health Education for Older Americans (H.R. 4472). I was struck with its close relationship with another bill you are developing (H.R. 4164--The Vocational-Technical Act of 1983). Your statement, especially page 5, suggests a new Title VII for the Older American Act. I believe there should be a close tie, by law, with this new Title VII (H.R.4472) and H.R. 4164, Title II, Part F. I hope you find this suggestion useful.

My best to you.

Sincerely,

Mike Latta

E. Michael Latta

EML:dsm

DEC 15 1983

Howard C. Miller, Ph. D.
3411 Wood Court
Raleigh, N. C. 27607
919 - 787 6039

December 12, 1983

U. S. Rep. Ike Andrews
2201 Rayburn HOB
Washington, D. C. 20515

Dear Rep. Andrews:

My congratulations on your health education bill. I think it is a foreward-looking, productive piece of legislation. You are absolutely right in placing the emphasis on health education as the best way to deal with the health problems in an aging population. I have some suggestions to make concerning the implementation of your healthe education program when it becomes law, and, I hope, some contributions in helping it to become law.

I am currently president of the Association of Retired Faculty at North Carolina State University. We represent some 400 retired faculty members and have 150 active members. We organized a year ago precisely to carry out such kinds of activities as you provide for in your bill for ourselves and others. We are an experienced, well-i formed group who can effectively carry out much of your program. We ask you to consult with us and to use us as the program develops.

We request that we be invited to appear at hearings on the bill and that we be informed of the time and place of scheduled hearings so that we may support this legislation.

Howard C. Miller, President
NCSU Association of Retired Faculty
Prof. Emer. Psychology, NCSU

—*Major Duty: To Enhance Vocational and Technical Education*

Sheboygan County
615 NORTH SIXTH STREET
SHEBOYGAN, WI. 53081

Office on Aging

(414) 459-3095
ILAJEAN HORWITZ, DIRECTOR

December 16, 1983

Gordon Raley, Staff Director
House Subcommittee on Human Resources
Room 2178
Rayburn H O B
Washington D. C. 20515

Dear Gordon,

I am very excited about your interest in developing a health promotion - disease prevention program and would very much like to work with you in this endeavor.

Like Congressman Andrews, I too have been interested in health care for many years. Since I began with aging programs ten years ago, I have been developing the nutrition sites into wellness centers.

Let me share some observations with you. The reason I feel that nutrition sites are the appropriate vehicle is because the meal serves as a catalyst to bring the elderly together at the same time. The programs take place immediately before lunch or after lunch. The presentations usually last no more than twenty minutes. Although persons who do not wish to eat with the group are encouraged to attend the health education programs, few do.

Enclosed is a listing of the programs and speakers for 1983. The only person paid from aging funds was the dietitian. No other class instructor was reimbursed for any expenses by the office. All programs, except on cancer and sexuality have been well received. Cancer programs were tolerated, sexuality was not liked.

Professionals have trained our staff in areas of mental health and nutrition and our staff has relayed the information to our participants. Again, we did not pay the mental health staff.

I have also enclosed the paper I wrote regarding this subject. Key principals are underlined.

It is my hope that after you receive these materials you will contact me so we can discuss this very important subject further.

Cordially,

Ilajean Horwitz
Director

IH/jas
Enc.

A HEALTH PROMOTION DISEASE PREVENTION MODEL FOR THE ELDERLY

by

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CHAPTER I INTRODUCTION

Americans are living longer. In 1900, there were only three million Americans aged 65 and over making up four percent of the population. Now there are 24 million comprising eleven percent. By the year 2030, it is projected that people 65 and over will number 50 million or seventeen percent of our population.[1]

The special needs of the elderly have become a national concern. The HEW book, Healthy People, the Surgeon General's Report on Health Promotion and Disease Prevention, allocates a whole section to the special needs of the elderly.

In his report to the nation, the Surgeon General, Julius Richmond, M.D., discusses the social and psychological factors of dependency in later life and points out that we now know what programs and services can help prevent deterioration; avoid needless institutionalization and maintain functional independence. He lists a variety of services and programs to enhance and maintain the physical, emotional, and social wellness of older people. To enhance physical well-being, the Surgeon General recommends a variety of screenings, dietary guidance, eye care, foot care, routine medical care, nutritious food available through Meals on

Wheels and group meal services, exercise, ready access (including by telephone) to advice from health professionals, and provision of eye glasses, hearing aids, talking books, and large print publications. To meet emotional needs, Dr. Richmond calls for counseling and volunteer and employment opportunities to provide a continuing sense of purpose in life. Regarding social needs, he advocates safe and affordable housing, communication and transportation services, including telephone and escorts; recreation and education programs to promote enjoyment, challenge and stimulation; community centers to offer social opportunity, legal aid, and in-home services such as homemaker, nurse, and home health care.[2]

The federal government has taken the lead in addressing many of the physical, emotional, and social needs outlined by the Surgeon General. Money is being pumped by the federal government into a variety of services and programs targeted at the elderly. In the area of physical needs, programs include Medicare and Medical Assistance, food stamps, congregate meals, and home delivered meals. Emotional needs are addressed by counseling services and several volunteer and employment programs. Federal support of social needs include financial aid, low cost housing, fuel allowances, winterization programs, transportation, senior centers, nutrition sites offering supportive services, legal aid,

consumer programs, and in-home services such as homemaker, home health aide, professional nursing, and chore service.

Prior to federal government involvement, there was no planned strategy at the local level to deal with the needs of persons in later life. As a result of federal legislation, money has been channeled to the state and local communities for programs targeted at the elderly. Some of the money went through established channels such as the Social Security Administration and Departments of Social Services. However, there was no local channel for receiving money authorized under the Older Americans Act of 1965. Therefore, it became necessary to provide both a planning and distribution mechanism at the local level.

In Wisconsin, funds authorized under the Older Americans Act of [illegible] were channeled to the state Division on Aging. In 1973, due to amendments to the Older Americans Act of 1965, it was mandated to identify Area Agencies on Aging, planning and services areas, which were to plan and coordinate services for the region. Nine planning and service areas were identified in the state and Area Agencies on Aging were established with federal dollars. Because difficulties arose regarding regional planning of county issues, in 1979, the state mandated county based planning to take effect in 1980. To implement this plan, it was necessary that each county have a coordinator of elderly services. Since many

Wisconsin counties did not have such a person, they used Title IIIB funds, which were authorized under the 1978 amendments to the Older Americans Act, to establish these positions. Without the impetus of federal dollars, it is debatable if many local communities would plan for the needs of their older residents.

County Based Planning

County based planning calls for each county to maximize the impact of federal, state, and local resources available to the county to meet the identified physical, emotional, and social needs, and to plan and develop strategies to fill the gaps in service that they find.

Policy for Sheboygan County Aging Programs is set by the Sheboygan County Board. The Board receives advice regarding aging matters from a county appointed Commission on Aging, comprised of nine community members and two County Board supervisors, namely, the Chairman of the County Health Committee and the Chairman of the County Welfare Committee. The County Commission on Aging and the County Welfare Committee constitute the Sheboygan County Aging Unit. This unit is charged by the state with the development of the County Plan. County-wide aging programs are administered by the Sheboygan County Office on Aging which has a staff of 22 persons.

Topic: Comprehensive Wellness Program

As director of the Sheboygan County Office on Aging, I am engaged in county-based planning. In this paper, I will deal with one aspect of our plan: the development of a comprehensive disease prevention and health promotion program which is appropriate for older persons who attend county operated Food and Fellowship sites, also known as nutrition sites. This is not a new program, but an expansion of an existing one.

Eleven Food and Fellowship sites are located in the county. The first four sites were opened in 1974; new sites were established each year with the most recent being opened in 1979. Throughout the years, the program has been federally-funded under the Nutrition Program for the Elderly which is part of the 1972 amendments to the Older Americans Act of 1965. Over 6,000 Sheboygan residents have partaken of one or more meals at one of the eleven Food and Fellowship sites since the federally-funded nutrition program began six years ago. In 1979, 2,081 different people participated.

The target population for the Nutrition Program for the Elderly is the low-income elderly. According to the program's Guide to Effective Project Operation:

> 'Eligible individuals' are those persons who are aged 60 or over and who:
> (1) Cannot afford to eat adequately; (or)
> (2) Lack the skills and/or knowledge to select and prepare nourishing and well-balanced meals; (or)

> (3) Have limited mobility which may impair their capacity to shop and cook for themselves; (or)
> (4) Have feelings of rejection and loneliness which obliterate the incentive necessary to prepare and eat a meal alone.
> The spouses of such individuals are also considered eligible individuals.[3]

There is no means test and anyone 60 or over or whose spouse is 60 or over may attend. The comprehensive disease prevention and health promotion program will be aimed at this same population, and will be open to anyone 60 or over or whose spouse is over 60, who wishes to participate.

The program features individual choice. An individual may participate freely in any aspect of the program which he/she chooses. One person may only wish to partake of the meal and not engage in any other service or activity. Another person may select to join in specific activities, but not partake of the meal. The individual makes the choice regarding the aspects of the total program which are of interest to him/her and he/she is free to participate as desires.

The county agency operates an outreach program, designed to reach the target population. It is assumed that those elderly who are aware of the Food and Fellowship sites and choose not to participate are: (1) effectively meeting their needs in the private sector, (2) do not wish to have the government involved in meeting their needs, (3) do not care to engage in disease prevention or health promotion

activities which are recommended in this paper, or (4) do not understand that it may benefit them.

Limitations of Paper

This paper will be limited to a discussion of the identified physical, emotional, and social needs of the target population and how we can deal with these needs at Food and Fellowship sites. It will only be concerned with those members of the target population who choose to attend the congregate centers. The intent is to offer an introduction to disease prevention and health promotion which can be appropriately handled in these settings. In-depth services are beyond the scope of this paper.

County Data

To aid in the development of the County Plan, the State of Wisconsin, Bureau of Aging, (change of status took place with reorganization of Department of Health and Social Services in 1977) provided 1975 census estimates and a survey of the nine-county region, which they recommended that the County use to develop the 1980 County Plan. Excerpts of the demographic information and the health survey provided by the Bureau and incorporated in the County Plan follow. Since this is the end of a census period and the data is approximately ten-years old, it is used here only to give some impression of the County.

Sheboygan County has a high percentage of elderly persons. Of the estimated 1975 county population of 99,440 persons, 17.5 percent or 17,363 people were 60 years and older. It is projected that the total number of people in this age group will increase to 18,474 in 1980, and to 19,147 in 1985.

Among the county's people over 60, it is estimated that 27.7 percent are between the ages of 60 and 64; 23.9 percent are between the ages of 65 and 69; 19.4 percent are between the ages of 70 and 74; 14.4 percent are between the ages of 75 and 79; and the remaining 14.6 percent are 80 years old and older.

There are 2,229 more female elderly people than male elderly people in the county; about 56.4 percent are females and 43.6 percent are males. Concerning very old people, there are 1,539 females aged 80 and older and 989 males over 80 years old.

The land area in Sheboygan County totals 505 square miles. Throughout the county, 67.4 percent of the older people live in urban areas and 32.6 percent live in rural areas.

In 1970, 10,099 persons over 60 lived in cities, towns, and villages with populations over 2500. These places cover 13.8 square miles. The other elderly people are scattered throughout the remaining 491.2 square miles of land. Most

services and activities for older people are provided in the more populated areas of the county. Therefore, an older person may have to travel as far as 15 miles to a populated area to receive needed services.[4]

In Sheboygan County, it is estimated that approximately 17.4 percent of the elderly people aged 60 and over are low-income persons. This figure does not take the elderly's resources into consideration. According to William White, director of Sheboygan County's Social Security Administration, many low-income elderly will not spend down their assets, therefore they are not eligible for SSI. In December, 1977, there were only 388 Supplemental Security Income recipients in the county who were 65 years old and older.[5]

Specific information regarding the general health status of the elderly in the county is not available. The following information collected in 1971 by the Wisconsin Department of Health and Social Services reveals the general health condition of people aged 65 and over in the planning and services area which contains Sheboygan County:

Health Status Indicators:	State Total	Planning and Service Area
(1) percent who were bothered by 'poor' health to the extent they were unable to do regular daily activities at least 'once in a while'	77%	75%
(2) percent who had a chronic health problem	49%	42%

Health Status Indicators:	State Total	Planning and Service Area
(3) percent who were bothered by a chronic health problem 'most of the time'	22%	17%
(4) percent who were sick sometime during the previous month to the extent that they could not go about their daily activities	19%	22%
(5a) percent who had difficulty performing regular activities	58%	50%
(5b) going up and down stairs	31%	28%
(5c) hearing people talk	23%	19%
(5d) cutting toenails	20%	18%
(5e) working around the house	19%	20%

Elements of Paper

Description of Elderly Needs

The physical, emotional, and social needs of older persons generally are identified. Physical needs are described in regard to natural aging. Tissue changes and systemic changes and consequences are explained. Since the overwhelming emotional state that older people must deal with is loss, the variety of losses that the elderly face is described. Social needs encompass income, living conditions, consumerism, attitudes to aging, roles, and socialization. A description of social needs is included.

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Description of Response to Needs

A wide range of comprehensive services, screenings, and health education programs are recommended to deal with the physical, emotional, and social needs of the elderly.

Assessment of Sheboygan County's Programming at Food and Fellowship Sites in Light of the Elderly's Needs

Sheboygan County's programming is evaluated in terms of the following criteria: (a) the comprehensiveness of health services that meet the physical, emotional, and social needs; (b) availability of service to as many of the target group as have need; and (c) efficient and effective delivery systems.

Steps Associated with the Development of the Wellness Model

The Wellness Services and Education Model Program is designed to provide the target population with a variety of direct services and educational programs to inform them about self-care and about other services available to them.

CHAPTER II REVIEW OF THE LITERATURE

"Old age can be an emotionally healthy and satisfying time of life with a minimum of physical and mental impairment," according to Robert N. Butler, M.D. and Myrna I. Lewis, ACSW, in their book, Aging and Mental Health.[7] Butler is a renouned gerontologist and psychiatrist, who won the Pulitzer prize in 1976 for general nonfiction for his book, Why Survive? Being Old in America. His perceptions of aging played a key role in the formation of the wellness model presented in this paper. This quotation by Butler and Lewis serves as a goal for programming at Food and Fellowship sites. The challenge was to develop a health promotion and disease prevention program which would assist in bringing about this state of well-being for our target population. In reviewing the literature, four factors, which we could address appropriately with the participants in congegate settings, became apparent.

1. Older persons should be encouraged to examine their lifestyles and make [illegible]. Former HEW Secretary Califano stressed the importance of lifestyles. He emphasized that persons of all ages should take control of their own health. He states:

You, the individual, can do more for your own health

> and well-being than any doctor, any hospital, any drug, any exotic medical device. Indeed, a wealth of scientific research reveals that the key to whether a person will be healthy or sick, live a long life or die prematurely, can be found in several simple personal habits; one's habits with regard to smoking and drinking; one's habits of diet, sleep and exercise; whether one obeys the speed laws and wears seat belts; and a few other simple measures.[8]

The U. S. Department of Health, Education, and Welfare recently published, A Guide to Medical Self-Care and Self-Help Groups for the Elderly. In the introduction, self-care is defined as "actions that we as individuals perform on behalf of our own, our family's, or our neightbor's well-being," and self-help groups are "clusters of persons who share a common condition, and who come together to offer one another the benefit of their experience and mutual support."[9]

The Lorenz-Davis model health promotion organization also stresses the vital role life-styles play. They quote the Canadian list of nine principles of living that promote wellness. They are:

(a) it is better to be slim than fat;
(b) the excessive use of medication is to be avoided;
(c) the fewer cigarettes smoked, the better it is;
(d) exercise and physical fitness are better than sedentary living and lack of exercise;
(e) alcohol is a danger to health, particularly when driving a car;
(f) mood-modifying drugs are a danger to health, unless properly supervised;
(g) tranquility is better than excess stress;
(h) the more responsibility one takes for one's own health, the better it is; and

(i) the less polluted the environment, the healthier it is.[10]

Your Life-Style Profile, a personal checklist developed by the Canadian government, is found in appendix IV.

2. **Health screenings should be available and accessible and older persons should be encouraged to attend.** Persons should participate in preventative services. The Surgeon General notes that some problems associated with aging can be detected and corrected at early stages. Therefore, he recommends that older adults should have health check-ups at least every two years until age 75 and every year thereafter. The following should be performed each time: blood pressure check (with follow-up and treatment, if warranted), hearing and vision exam, breast exam for women, urinalysis, and hematocrit (measurement of red blood cells). At less frequent intervals, women should have pap smears, and all should have stool examined for blood. When possible, these and other preventive services such as foot care, dental care, and dietary guidance should be provided at a single location.[11]

A national strategy has been developed to promote health screenings. The National Health Screening Council, Inc. (NHSCVO) which was organized in 1974, has developed a health fair model which was distributed throughout the Administration on Aging's "aging network" in 1979 and again in 1980. As defined by NHSCVO,

> A health fair is a concept of providing a community based health promotion and disease prevention

package which includes: health education, preventive health screenings, counseling and referral, and follow-up of participants found to have potential significant problems or needs as a result of the health fair

When organized to include each of these components, a health fair can be an effective tool in providing individuals with the information they need to make responsible and appropriate decisions about their health and their lifestyle as it affects their health. It can also be an important vehicle for imparting information about existing community resources and programs to the senior population of an area.[12]

Two specific health screening objectives stated by NHSCVO for their health fair model are:

(1) to provide health screenings for as many diseases as possible, where specific simple mass screening tests are available, and where early detection and treatment can significantly decrease the morbidity associated with the disease, and (2) to provide the health screening at no charge to the participant, or at a very reduced charge to just cover expenses where the screening cannot be done free.[13]

3. <u>Pertinent educational information should be available and accessible</u>. Educational programs should provide advice and assistance to older persons in dealing with a wide range of physical, emotional, and social problems.

Minkler's survey of the "Health Attitudes and Beliefs of the Urban Elderly" indicates the need for education, especially of the low-income elderly.

A brief synopsis of the study and its results follow:

Selected health beliefs, attitudes and practices of 755 elderly residents of a large metropolitan area were surveyed in 1976. Middle class, lower middle class, and low socio-economic groups were represented.

A thirty-item questionaire was administered to

> elicit information on the respondents general life satisfaction; perceptions of their own physical, mental, and emotional health compared with those of others in their age group; attitudes toward specific disease prevention or health promotion activities; and beliefs about normal aging processes.
>
> The low-income group demonstrated significantly less favorable perceptions of their physical health status then did their counterparts and a far greater tendency to report that they saw an M.D. 'only when feeling ill.' They also appeared to be misinformed about preventative health behavior to a significantly greater extent than members of the other two subsamples. In particular, their exaggerated faith in vitamin pills shown by this group of elderly poor, as well as their significantly greater tendency to believe that their working automatically disqualified them from Medicare.
>
> The study results also point up the needs for better health education of the elderly and more public health intervention in their behalf to counter the prevalent stereotypes of the elderly and the misinformation on which many of the elderly's health related beliefs, particularly those of the poor are based.[14]

Combs talks about identifying the individual's needs and promoting change in the person.

She approaches education from the nurses' viewpoint. She explains,

> The nursing process of data collection, problem definition, planning, implementation, and evaluation is applicable in promoting optimal health status of older adults using a preventive approach. First, the nurse must collect data regarding the older adult's health status; physical health, mental health, nutrition, and such health habits as sleep and activity, along with the environmental conditions in which the older adult lives.
>
> From this data, the nurse identifies the outstanding problems or conditions that may increase the older adult's risk for morbidity or mortality and develops a plan of intervention. Implementation of the plan and evaluation of the results are then carried out.[15]

According to Comba,

> Preventive health care does not end with an annual physical exam. It plays an important role in influencing the quality of life for the older adult. Old age is not too late for change. Changes to reduce risks can often mean the difference between healthful living and crippling disabilities or death.[16]

4. **A large spectrum of services should be available and accessible.** Older persons should be able to easily avail themselves of specific services to meet their existing physical, emotional, and social needs.

Characteristics of Elderly People

To specifically ascertain the kinds of services and programs that will be benefical to older adults to maintain and enhance the quality of their lives, we must first look at this age population in terms of their physical, emotional, and social characteristics. This section is not intended to be a scholarly review of scientific research into the field of aging. It is meant only to provide background material in support of the recommended health promotion, disease prevention program. Let me stress that the state of the art is tentative and many researchers disclaim universality, validity, and reliability.

Physical Aspects

People age differently. Everyone does not age at the same rate. Some 90-year olds look and act young for their age -- some 60-year olds look and act like 90.

There is little information and agreement as to what constitutes natural aging, although there is data to indicate a slowing down in physiological function with age.

Nathan W. Schock gives an overview of the state of the art by stating,

> With the virtual conquest of want and infectious disease in technologically advanced countries, men and women in increasing numbers are living out the promised Biblical life span of three score years and ten. The diseases of age and the fundamental process of aging are moving to the center of interest in the practice of medicine and in medical research. Few people die of old age. Mortality increases rapidly with age--in precise logarithmic ratio to age in the population as a whole--because the elderly become more susceptible to diseases that kill, such as cancer and cardiovascular disease. The diseases of old age are the province of the relatively new medical specialty known as geriatrics. A still younger discipline called gerontology deals with the process of aging itself. This is a process that continues throughout adult life. It goes on in health as well as in sickness and constitutes the primary biological factor underlying the increase in susceptibility to the diseases that are the concern of geriatrics.
>
> Gerontology is still in the descriptive stage. Investigators have only recently developed objective standards for measurements on statistically significant samples of the population. The first general finding in gerontology is that the body dies a little every day. Decline in capacity and function over the years correlates directly with a progressive loss of body tissue. The loss of tissue has been shown to be associated in turn with the disappearance of cells from the muscles, the nervous system and many vital organs. To get at the cause of death in the cell, gerontology has entered the realm of cellular physiology and chemistry.[17]

Some of the specifics that scientists point to regarding natural aging are as follows:

Tissue Changes

Bones and Joints. There appears to be decrease in bone mass, frequently resulting in increased stress in weight-bearing areas that become predisposed to fracture. Calcification within cartilage and ligaments is observed to some degree in a majority of older individuals (Smith and Bierman, 1973). The cartilage between the joints wear think and irregular. There is a decrease in the fluid that lubricates their inner surface. Arthritis superimposed on these changes increases the distress. Foot problems limit mobility.

Muscle. Muscle size and strength both diminish with age. Although regeneration of muscle is still possible in the older person, muscle mass does decrease gradually but steadily. This loss may be secondary to the decrease in activity as well as to changes in the connective and circulatory tissues so closely connected with muscle.

Nervous, Sensory. Some experts say that a decrease in efficient function in all senses occurs with time. If there are decreases in smell and taste, this can affect appetite and finally nutrition. Hearing and vision may decrease. According to Weg, about 95 percent of the elderly retain their vision with the aid of glasses. About one-third get cataracts. Most elderly over 65 cannot hear high-pitched tones and they are prone to ear damage. Other changes may include a decline in touch sensitivity, a

decrease in perception of vibration and temperature, and an increased pain threshold.

Systemic Changes and Consequences

Pulmonary System. There is a measurable reduction in breathing efficiency with age. The decreases in maximum breathing capacity, residual lung volume, total capacity and basal oxygen consumption bring about a diminished metabolic rate.

Digestive System, Nutrition, and Teeth. Changes in the digestive juices, a reduction in peristalsis, and constipation are changes noted in the digestive tract of older persons. Nutrition is considered a very significant element in the proper functioning of the digestive system. Studies indicate there is a considerable amount of malnutrition among the elderly.

There is some evidence that loss of teeth and periodontal disease could be prevented. Although there is a suggestion (Slavkin, 1974) that some individuals may have a predisposition to periodonitis, there is also the indication that prevention may take place with adequate professional dental care, personal care, and balanced diet.

Cardiovascular/renal. Both systems undergo changes leading to lowered efficiency. The heart has to pump harder thus limiting the amount of physical work older persons can do. Peripheral resistance, circulation time, as well as

distolic and systolic blood pressure often increase with age. This is especially so in those individuals whose blood vessels have narrowed because of atherosclerosis and arteriosclerosis.

Nervous System. There is little functional change although there is a gradual replacement of nerve tissue by fibrous cells. Slower reaction and reflex timing results.

Immune and Endocrine Behavior. Hormones promoting immunity responses decrease and those remaining do not affect the same degree of response. Age associated decline in glucose tolerance is fairly universal with age.

Sexual Changes. Gonadal hormones also decrease over time in men and women. This decline produces slow, involutionary changes in genital tissue, a reduction and finally possibly loss of fertility, but no consequental or inevitable loss of libido. While interest and capacity persist through old age, activity declines most frequently due to illness or unavailability of a suitable mate.[18]

Drugs and Changing Physiology. Drug therapy in the elderly requires an understanding and incorporation of changing functional levels particularly in absorption, detoxication, and excretion of drugs.[19]

Approximately 80 percent of the older population have some chronic condition. Scientists point to several factors to explain the conditions found in old age. They talk about

genetic factors, disease states that occur in advanced age and lend themselves to treatment; exposure to some pathogenic elements such as too much sun, cigarette smoke, and air pollution; and poor health habits and lack of treatment in the early years.[20]

Ruth Weg points to several areas of physiological dysfunction and relates them to areas of the environments.

arteriosclerosis atherosclerosis coronary disease hypertension	and	high fat, high carbohydrate diet; sedentary life style; tension; cigarette smoking
cerebral accidents	and	atherosclerotic and arteriosclerotic changes
chronic pulmonary disease	and	cigarette smoking; air pollution
obesity	and	high caloric intake; lack of exercise
osteoporsis	and	inadequate calcium and protein intake
peridontal disease	and	malnutrition
'senility'	and	malnutrition; social isolation
sexual dysfunction	and	ignorance; societal stereotypic attitudes[21]

Many of these items do lend themselves to change. Studies show that continued use and exercise of many physiological capacities prolong retention of those capacities.

Dr. DeVries has demonstrated that an exercise regimen of six to eight weeks regains some of the muscle strength and tone among old men 60-90 years.[22]

Other studies indicate that even the rate of atheromatous plaque formation is slowed down by exercise and the risk factor of sedentary life-style for coronary artery disease is reduced significantly (Stamler and Epstein, 1972). Cardiovascular efficiency may also increase and maximize the limited capacity of individuals who are already at risk with coronary disease. A measurable improvement is aerobic ventilation and usable oxygen is another benefit of exercise.[23]

Emotional Aspects

The overwhelming emotional state that older people must deal with is loss of some kind. Retirement often means loss of job, loss of income, and loss of status. Other losses that the elderly have to deal with are loss of a spouse, loss of friends, and loss of health.

Retirement

When a husband retires, there is a possibility of marital problems. With this age group, most of the women did not work. Therefore, the woman was home alone during the day. Now the husband is also home and if he didn't plan for his retirement, he is likely to be underfoot. Work and life are often intertwined. The woman still has her role of housewife, but often the man has difficulty find a meaning in life without work. The retiree often links productivity to value. Without a job, he often feels worthless.

Widowhood

The loss of spouse represents a major psychological concern. Statistics show that 56 out of every 100 elderly become widowed (three times as many women as men). The grief process takes place at the same time that other decisions must be made--financial decisions, living arrangements, what to do with the deceased personal effects, etc. Often the remaining spouse is not familar with finances, insurance, etc. Many widows never drove a car so transportation may now be a problem.

Sensory Loss

About 30 percent of older persons experience significant hearing loss. This can reduce reality testing and lead to marked suspiciousness and even paranoia. From clinical observations, it has long been thought that a relationship exists between hearing loss and depression. Hearing loss creates greater social isolation than blindness. Loss of other sensory aspects also were related to depression.[24]

Loss of Physical Health

Physical states have significant relationships to emotional states. Many emotions come into play when people are ill, such as fear and anxiety about death; feelings of helplessness and vulnerability; and shock and disbelief at body changes.

Besides loss, the elderly have to deal with feelings of

guilt, anger, loneliness, and helplessness. To cope, the elderly, like other age groups, have to be adaptive, flexible, and deal with change. Like other groups, they make use of a variety of defense mechanisms. However, the elderly do have fewer reserves to draw on and some do not adapt. Presently, the highest rate of suicide occurs in white males in their 80s. The elderly account for 25 percent of all reported suicides (5,000 to 8,000 per year). The most preventable are thought to be those related to depression, in which suicide represents a passive giving up. The major method of reducing suicide is the provision of good treatment early on in the course of the depression.[25]

Social Aspects

Generally, the elderly have been ignored by society. Society values production, vitality, youth. The elderly remind society of its own mortality. A high percentage of elderly live in poverty or near poverty--to proud to ask for help. Many stereotypes persist regarding older people. They are often thought of as decrepit and living in nursing homes. In reality, according to the Surgeon General,

> Most elderly Americans can and do remain in their own homes. In 1975, 77 percent had their own households (51 percent lived with a spouse and 26 percent lived alone); 18 percent lived in a home with someone other than a spouse; and only five percent were institutionalized.[26]

He feels,

> With the provision of adequate social and health services, even more older people would be able to maintain a relatively independent life-style, and the quality of life for the majority would be vastly improved.[27]

Social roles change and social loss occurs as persons age. Social identities and relationships change with retirement. Early retirement leaves many people with one-third of their lifetime still ahead of them. There is often the loss of a spouse and frequent losses of friends. Widows are often not accepted with couples, so the loss of a spouse may also mean the loss of significant others.

The Surgeon General relates,

> Some gerontologists have suggested that 'disengagement' from life is a normal part of the aging process. However, most gerontologists now dispute the theory and contend that disengagement is imposed on the elderly by such factors as physical immobility, poverty, and social isolation.[28]

The positive role senior centers play in alleviating social isolation is discussed by Minna Field. She explains,

> Those in close contact with the aged and their problems, are convinced that fruitful utilization of leisure time, properly adjusted to the older man's reasonable interests and abilities, can be of inestimable value to him spiritually as well as physically by giving purpose and meaning to his life. In this way, old people can be encouraged not only to socialize, but to enjoy their solitude more constructively.[29]

She goes on to say,

> The beneficial effect on such programs has been noted by such authorities as Dr. W. C. Menninger, who says: 'Recreation is an extremely important

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> aid to growing old gracefully. People who stay young despite their years do so because of an active interest that provides satisfaction through participation.[30]

E. Lazarus also supports the value of congregate settings. He points out,

> The isolation, loneliness, and passivity, formerly so much a part of aging, can be decreased or eliminated if the older person participates in suitable recreational activity. Together with members of his own age group, he begins to develop new relationships and friendships, finds new warmth and security. Through achievement in some phase of the program, he gains status with his group, and frequently, with members of his family as well. The older person finds great satisfaction in his ability to learn new skills, and to discover latent talents. Life takes on new meaning as he finds himself productively involved, useful, and wanted.[31]

Economic Considerations

Because 80 percent of the older people have chronic conditions, they spend more on drugs, are more likely to see a physician, and tend to have more and longer hospital stays (Botman, 1973). Their medical treatment accounts for about 30 percent of the nation's health care expense.[32]

Older people play an important role as consumers. In 1965, older adults were spending 12 percent of the total money spent on goods and services; by mid 1970, this share equaled about sixty billion dollars.[33] The elderly represent a stable and reliable market; they are not subject to impulse buying. Purchases are concentrated in the areas of medical care, food, and personal care.

A reciprocal relationship between the economic resources

of the aged and their health problems has been noted. The reduced economic resources of the aged encourages both a crisis-oriented approach to health care (Suchman, 1966) and an inadequate diet (Guthrie et al, 1972). The neglect of preventative health care increase the already high probabilities of disabling illness. Poor health, in turn, aggravates the economic strains associated with old age.

Butler notes that "old people are victims of violent crime more than any other age group."[34] He also says,

> Old people are victimized in many ways other than through violent crime. They are pursued by fortune hunters anxious to separate them from their pension checks. Door-to-door salesmen offer persuasive 'bargains' bolstered by 'free' gifts and prizes. Those with visual handicaps are cheated when change is made in stores. At a time of loss and grief, first the funeral directors and then all kinds of salesmen--dealing with real estate, investments, and the like may exploit them. Cosmetic firms make them feel they are ugly and extract their money in exchange for 'youth-restoring' beauty aids. Quack doctors, appliances, and drugs give them false hope. Pharmaceutical firms realize high profits from unnecessary sales to the elderly.[35]

Bring About Change

Can the elderly learn different patterns of behavior? Richard Videbeck in Lowy's book, Social Work with the Aging, says they can. He maintains that the ability to learn does not change basically to any substantial degree with aging. Although reduction in sensory acuity may make it more difficult for the older adult to learn certain procedures involving dexterity and sensory perception, the

healthy older adult with unimpaired intellectual capacities will hold his own with younger adults when it comes to learning. Older people learn much better if they have a substantial interest in the subject, if they are strongly motivated, (and) especially, if they can use familar methods of reorganizing their ideas.[36]

Jeanne C. Hellburg offers twenty guidelines for the teaching of aged adults:

> The following guidelines take into consideration selected sets of conditions identified by research that influence the learning of aged adults:
>
> 1. Select visual aids that minimize the need for visual acuity or precise discrimination.
> 2. Seek a position in physical relationship to the person so as to maximize the strength and clarity of sensory stimuli.
> 3. Adjust word/min rate to a level that makes the auditory inputs clearly perceptible to the person.
> 4. Determine with the older person the type of aid or media for input that facilitates his learning; e.g., auditory, visual, tactile, or some combination.
> 5. Utilize teaching strategies or materials that permit the person to control the presentation pace of content to be learned.
> 6. Seek feedback from the person regarding such things as pace, speech intelligibility, meaningfulness of content.
> 7. Select a place and time when simultaneous activity in the environment will be minimal in order that competing simuli will not disrupt the person's learning.
> 8. Select a time for teaching when the person is not preoccupied with other concerns, e.g., recovery from illness, grieving, or finances.
> 9. Provide opportunities for recall of new information and practice of performance of tasks preferably within a day's time, or within a week of presentation at most.
> 10. Relate new learning to the past and present experiences of the person.

11. Integrate new behaviors with established and ongoing behaviors and activities so as to enhance memory.
12. Establish goals for learning that are mutually agreed upon by the older adult and the practitioner.
13. Establish short-term goals that are achievable and related to long-term goals in a meaningful way.
14. Determine what constitutes positive reinforcement for a given individual.
15. Provide opportunities for successful learning, prompt feedback, and ample reinforcement for the level of performance achieved by the individual.
16. Encourage the person to participate in decisions related to when, how, and what learning is to occur.
17. Encourage the expression and utilization of information brought by the older person to the teaching-learning situation which concerns the individual and situational variables operating in his life and which may relate to his learning.
18. Utilize terminology and examples familiar to the individual.
19. Consider the person's comfort and level of available energy.
20. Capitalize on the older person's (and one's own) reservoir of common sense and sense of humor.[37]

She goes on to say,

> These guides are not mutually exclusive and certainly not all inclusive. They do, however, constitute an effort to provide a rational basis for practice that is related to the teaching of aged adults. It is, in the final analysis, up to the practitioner and the older adult to select and utilize what appears to be appropriate, meaningful, and timely.[38]

Health Promotion Recommendations

Having reviewed several, although not all, characteristics associated with the physical, emotional, and social aspects of aging, we can now link these characteristics with specific recommendations in regard to life-styles, screenings, education, and activities. I have chosen to do this by listing each area of concern, and then recommending the life-style changes, screenings, education programming, and activities that apply to it. The following health promotion recommendations are based on my interpretation of the literature dealing with some of the physical, emotional, and social aspects of health promotion and disease prevention.

Health Promotion Recommendations

Physical Area of Concern		Recommendations
1. Tissue		
Bone	life-style:	proper diet
	education:	nutrition education to prevent osteoporosis foot care education
	activity:	foot care
Joint	education:	arthritis
Muscle	life-style:	exercise
	education:	exercise
	activity:	exercise classes
Nervous/sensory	life-style:	environment concerns
	screening:	hearing, vision, cataract, glaucoma
	education:	hearing, vision hypothermia
	activity:	hearing aids, eye glasses, large print and talking books
2. Systemic Systems		
Pulmonary system	life-style:	do not smoke
	education:	do not smoke
	activity:	stop smoking self-help group
Digestive system, nutrition, teeth	life-style:	proper diet
	screening:	oral exam, stool exam
	education:	nutrition, dental
	activity:	nourishing meals

Physical Area of Concern	Recommendations	
2. Systemic Systems (continued)		
Cardiovascular/renal	life-style:	exercise, do not smoke
	screening:	blood pressure, blood
	education:	exercise, do not smoke
	activity:	exercise classes, stop smoking self-help group
Nervous system	life-style:	defensive driving
	education:	defensive driving
	activity:	transportation
Immune and endocrine behavior	screening:	blood testing
	education:	diabetes
	activity:	immunizations
Sexual change	education:	sex
Drugs and changing physiology	life-style:	drug use
	screening:	urinalysis, breast exam and pap smear for women
	education:	drug use and abuse

Emotional Areas of Concern	Recommendations	
1. Retirement	life-style:	retirement activities
	education:	preretirement planning socialization attitudes economics health care and using the system insurance legal
	activity:	socialization opportunities job opportunities volunteer opportunities economic, legal, and insurance counseling
2. Widowhood	life-style:	living alone
	education:	death and dying coping skills to deal with loss and stress economics
	activity:	economic counseling recreation activities transportation
3. Sensory Loss	life-style:	coping with sensory loss
	education:	alternatives
	activity:	counseling hearing aids glasses large print and talking books
4. Loss of Physical Health	life-style:	coping skills
	education:	coping skills
	activity:	counseling for depression, stress, loss transportation

Social Areas of Concern	Recommendations	
1. Low Income	life-style:	budgeting
	education:	budgeting
	activity:	social security, supplemental security income food stamps fuel assistance low-cost housing transportation
2. Living Conditions	life-style:	alternative living patterns
	education:	alternative living patterns
	activity:	home services (visiting nurses, homemaker, mobile meals) chore service respite care home maintenance day care retirement housing
3. Consumerism	life-style:	purchasing
	education:	consumer
4. Attitudes to Aging and Roles	life-style:	roles
	education:	mental health
	activity:	counseling
5. Socialization	life-style:	sociability
	activity:	recreation

CHAPTER III IDENTIFYING THE GAPS

We have ascertained the general physical, emotional, and social needs of this older target population necessary to maintain and enhance wellness and have approached the needs in terms of life-style, screenings, education programming, and activities.

Criteria Used

Let us now turn to Sheboygan County to evaluate the County's existing services to this specific group in terms of the following criteria:

1. The comprehensiveness of health services that meet the physical, emotional, and social needs. In the last chapter, we identified a broad spectrum of life-styles, screenings, educational programs, and specific activities that have an impact on the well-being of older persons. In this chapter, we will group the health promotion recommendations together and refer to all physical, emotional, and social needs of older persons as part of the "range of services."

2. Availability of service to as many as have need. Unless all targeted persons who need services can have access to them, the overall program is not successful. Therefore,

[redacted] needs with regard to access. Are all persons in the county, who desire to participate in the Food and Fellowship program, able to do so? Are the resources sufficient? Is the service offered within walking distance of recipients' homes or do they have adequate transportation to go to the services?

3. Efficient and effective delivery systems. Are the federal, state, and local dollars being maximized? Is duplication avoided? Are all resources being tapped? Is the service being offered where elderly people congregate? How often are services offered? Are they offered too frequently or not often enough? Can the intended participants see, hear, and understand the service being offered? Do the services meet the specific needs of the clientele?

Now let us examine each of these three criteria in relation to meeting the specific physical, emotional, and social needs of Sheboygan County's elderly.

Application of Criteria

Physical Needs

The Surgeon General recommended a check-up at which time several screening procedures would be performed.

The Sheboygan community has approximately forty-seven primary care physicians or one physician per 2115.7 county residents. The Northeastern Wisconsin Health Systems Agency

says that one physician per 2500 population is the standard. By that standard, Sheboygan County has an adequate number of physicians.

Physicians are accessible. They are located throughout the county and transportation is provided to them for the target group by the county. Although check-ups are accessible and adequate from local physicians, certain barriers do exist to receiving service. Cost is the most significant factor. Since many targeted elderly live on low incomes, they do not want to spend their incomes or touch their assets for prevention services; they will only use the doctor in crisis situations. Lack of a personal physician is another barrier. Some of our participants no longer have a personal physician. Their physicians have retired or died, and they have not chosen another. Often they do not know how to go about choosing a replacement. Fear is another reason that older adults do not seek out a physician. They may be afraid of the unknown--the procedures, the tests, and the costs. Although transportation is available from the county, some older persons think of county services as charity and therefore will not use the vehicles. Others say, "If I have lived this long without going to the doctor, I am not going to start now."

An alternative to going to a Sheboygan County physician for preventative services is to attend the Annual County-wide

Senior Citizens Health Fair. The health fair was instituted in 1977 to fill the gap for those elderly in the county who were not seeing a physician for preventative screening services; and also, to provide health education to this age group. Screenings for vision, glaucoma, hearing, hypertension, diabetes, anemia, weight, height, and oral cancer were conducted at the health fair. Because of the facility's physical limitations, the fair did not offer pap smears, breast exams or stool exams, which are encouraged by the Surgeon General. A blood test is used to screen for diabetes instead of the urinalysis advocated by the health official, and breast self-exam information is provided in place of the actual screening. Nurse counseling completes the screening aspects of the health fair.

With regard to the range of services, the fair makes available all the recommended screenings except pap smears, stool exams, and breast exams. These tests should be added to make the preventative screening effort complete.

As to reaching those members of the target group in need of service, statistics are not available as to how many of these older people in the county have a personal physician and visit him/her on a regular basis for preventative services. Nor, are there statistics regarding how many of the 400 persons screened at the fair last year, who also received preventative services from a personal physician.

What can be said is that all older persons in the county have access to prevention services either through a private practice physician or at the Annual Senior Citizens Health Fair. It should also be noted that the fair is well publicized, held in a central location, and transportation is available. Screeners at the fair are local dentists, an audiologist, hospital medical technologists, city and county nurses, and instructors and students from the health professions at Lakeshore Technical Institute.

Service providers were surveyed at the completion of the fair each year. Evaluations from these screeners and health exhibitors indicated that the health fair is an efficient and effective way to reach a large number of older persons in a coordinated fashion with minimal resources. No charge was made for any service. If the elderly who are screened at the fair do have screening results from personal physicians, there may be some duplication of service. However, there might be some benefit to having a second test. The second test may reinforce the first or there might be a change in the condition.

In addition to health screenings, the previous section identified the need for services and educational programs and/or activities to meet the physical needs of the older target population.

The main places where these services and programs are

provided in Sheboygan County are at eleven Food and Fellowship sites. These sites, which are located in areas of high concentration of older people, serve as focal points for delivery of services and programs for senior citizens. Three sites are in senior centers, three in churches, two are in restaurants, two in municipal buildings, and one is in a private building. Six sites are open five days a week; three sites are open two days a week; and two sites are open one day a week. In the last year 2,081 different people, 60 or over, participated. Average daily attendance at the largest site was 125 and at the smallest was 27. Outreach, information and referral, and transportation were provided throughout the county. These services served as feeders to the sites.

Most of the physical needs of these elderly, both in the area of service and education, have been addressed at the Food and Fellowship sites to some degree. As to service delivery, in 1979, hot meals were offered each day the sites were open; blood pressure screening was offered at least bi-monthly; flu shots were given; and, an eye care clinic was provided at eight locations. A foot care clinic was held in one location several years ago. It was not very successful and was not repeated.

Regarding programs in 1979, exercises were done daily; nutrition education was conducted monthly; and, drug use

and abuse was discussed once at each site.

Other subjects were covered sporadically and not in all locations. For example, an audiologist spoke at only one location last year. Defensive driving classes were held in four locations in five years. Hospital staff members went to each site last year to promote classes held at the hospital for diabetes and arthritis. Subjects not covered were sexuality, dental care, glaucoma, cataracts, and general health assessments.

Physical Needs: Conclusion: the Gaps

The range of services should be broadened to include sexuality, dental care, glaucoma, cataracts, and general health assessments. Scheduling must be improved so all locations receive all programs.

At present it appears that the physical services and programs are available to the target population who have been reached. Certainly, we have not reached everyone. Outreach and public information are ongoing processes. As more services are offered and more persons have need of them, additional effort must be made to make people aware of the activities which will meet their specific needs.

The programs can be handled more efficiently and effectively in terms of scheduling, program content, and type of presentation. Scheduling will be handled in the main office by one person instead of some programming being

scheduled by site managers and other programming being planned in the office. With one person responsible for this activity, there will be accountability. Overlap and duplication, which occurs when several people handle programming, should be avoided. This system will not exclude participants' involvement in programming. They have been involved in program planning in the past and they will be queried regarding their program preferences on a regular basis in the future. More effort will be put into determining the specific material to be covered in dealing with a topic. Consideration will be given to the type of presentation that will make the greatest impact on the participants. It is important to choose a presentation format that will be accepted by the elderly. Methods that were used in the past will be analyzed and those that were effective will serve as a model for future presentations.

Emotional Needs

A comprehensive range of health services that address the emotional concerns of these specific older adults is available in the community, although many aspects are dealt with superficially--either in an introductory manner or on a limited basis. Some of the emotional needs of the targeted elderly are met at the Food and Fellowship sites. Socialization is a major one. Several participants have told us that coming to the sites gives them a reason to get up in

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the morning. Some, whose spouses have died, said that during the grieving period, they do not know what they would have done if they could not have come to the site. There have been instances when a couple participated in the program and one member died, the remaining spouse came to the site for support in the interval between the spouse's death and the funeral. The project council, which is comprised of participants and community people, was asked what they perceived was being done at the sites to help in the adjustment of recently widowed persons. They felt that the companionship provided by the participants to the remaining spouse was itself a very valuable support system. Many participants comment that the socialization at the sites is the main reason they attend.

The Food and Fellowship sites offer many opportunities for volunteerism. Over three hundred volunteers contributed 26,199 hours of volunteer service there in 1979. Information is disseminated regarding job openings in the community and experts offer general economic advice, legal advice, and insurance counseling.

Other community resources are also concerned with the emotional needs of the elderly and some of the target group go to them for assistance. They include private practice psychiatrists, the Mental Health Center, the Sheboygan County Department of Social Services, non-profit counseling

agencies, the crisis intervention hot line, Legal Aid, the Sheboygan County Life Insurance Underwriters, the churches, the banks, and employers. The elderly may seek help on their own or may be referred by personnel from the Food and Fellowship sites or by other individuals or agencies.

We do not know if the community resources are sufficient to meet the target group's emotional needs because we have not identified a significant number of elderly participants or other members of the target population with unmet emotional needs. However, we can say that there is access to existing services. Transportation is available to all who wish to attend the Food and Fellowship sites. Urban elderly have daily service and rural elderly are transported at least twice a week. Older persons are also transported to other service providers. Transportation not only meets the need for access to service, but also plays a key role in reducing physical and social isolation of older people.

Services to meet emotional needs of participants at Food and Fellowship sites are delivered in the same manner as services to meet physical needs. Most subjects that impact on emotional well-being were addressed in an introductory fashion and many of these topics were only presented sporadically. For example, few job openings were posted, only some areas of economic advice were covered, no legal advice was offered for several years, a psychiatric social worker talked

once at each site during the year about Mental Health Center services, an insurance agent spoke about Medicare supplements at each site, and insurance counseling was handled by appointment. Except for the Office on Aging, which contacts elderly persons whose spouses have died recently, no community group does outreach directed at older persons with emotional problems.

Emotional Needs: Conclusion: the Gaps

The whole range of mental health issues for our target population is covered to some extent in the community at large. For example, church groups and educational institutions offer classes on death and dying, coping skills, dealing with stress, and managing finances. However, these programs are not: (1) specifically for the elderly, (2) held on a regular basis, (3) effectively publicized, or (4) coordinated. Let us take classes on death and dying as an illustration of the problem. On occasion, some churches, the local hospitals, the Mental Health Association, and the Lakeshore Technical Institute will sponsor courses dealing with death and dying. The only pre-class outreach efforts are brief notices in the local newspapers announcing where the programs will be held, when they will be held, and possibly, some reference to program contents. There is no further effort to reach our target group or to coordinate class schedules with other service providers. To attempt

to improve this fragmented situation, at least for persons who choose to attend the Food and Fellowship sites, we recommend that all subjects dealing with emotional needs be introduced at the sites and that the participants be referred to appropriate agencies for in-depth assistance. A typical illustration is that many of the participants have to deal with loss of spouses; therefore, we suggest introducting information on stress, the grief process, managing finances, and changing roles and responsibilities at the sites. Persons needing more help than the introductory information, that can appropriately be given at the sites, would be referred to other agencies for further counseling.

Recommendations cited earlier to improve availability and delivery of services to meet physical needs also apply to the emotional needs. Another aspect of the delivery system, that should be considered, is the lack of competent resource people to deal with emotional problems of later life. To cite an example, most of the Mental Health Center services are provided to younger clients. Since these professionals usually deal with youth and family problems, some are not equipped to effectively handle problems of the elderly.

A preventative program for middle-aged people, that can significantly reduce the problems associated with later life, is preretirement planning. Most of the current target

population did not have the benefit of preretirement planning. Few employers in the community conduct preretirement planning classes for their employees, so most retirees are not well prepared. A coordinated community effort should be considered to prepare middle-aged persons for retirement, so some of the emotional problems associated with later life can be avoided.

Social Needs

Most social needs of the target population are handled well. A comprehensive range of services existed in 1979. Many elderly, who attend Food and Fellowship sites, are living on low incomes. Information about Social Security, SSI, food stamps, and fuel assistance is available and services are provided. To aid these older consumers, consumer education is offered monthly at each Food and Fellowship site. Low-cost housing units are located throughout the county and others are in the process of being built. Transportation is available for social activities and payment is by donation, so lack of funds should not be a barrier to mobility.

Many social activities have been planned for these senior citizens. The Food and Fellowship sites have offered a myriad of programs based on the elderly's preferences. They include bowling and dartball leagues, crafts, dances, bingo, cards, films, etc. Senior centerr also offered many recreational activities geared to these elderly. In addition, the community has many recreation opportunities enjoyed by

our target population such as plays, musical events, and sports.

To assist the frail elderly, who can no longer attend the congregate program and who wish to remain in their homes, the Visiting Nurses Association offers skilled nursing services, mobile meals, and homemaker-home health aides. By referral, county and city nurses provide information to these elderly in their homes. The Office on Aging keeps a chore service exchange, home maintenance information, and tools for this elderly group.

Food and Fellowship participants have indicated a need for respite care and day care for their frail spouses and friends. These two needed services were not offered in 1979. Model projects are planned for both these areas in 1980.

Except for the availability of low-cost housing--over six hundred Sheboygan County older persons are on the waiting list--social programs are available to all who qualify.

The programs are well publicized in the local media. See the menu listing in appendix V. The outreach worker and I&R specialist also promote and explain them.

Delivery of social programs is generally efficient and effective. It could be improved if Social Services and Social Security would conduct business for the elderly at the Food and Fellowship sites. Thus, the elderly would not

have to go to their offices for service. However, at this time, the agencies say they cannot process applications at the Food and Fellowship sites because of privacy requirements and staffing patterns.

Summary: The Remaining Need

Range of Services

Sheboygan County offers a wide range of services to meet the physical, emotional, and social needs of the target population in later life, although there are some gaps in service.

Physical health promotion was divided between screenings, other services, and education. All screenings can be obtained from private practice physicians who were accessible. For those persons who did not choose to see a personal physician, a yearly Senior Citizens Health Fair offered most of the basic screenings recommended by the Surgeon General. Screenings not offered were pap smears, stool exams, and breast exams. Other physical services were offered at the Food and Fellowship sites, some sporadically. Many health education topics were discussed. Subjects not covered were general health assssments, sexuality, dental care, glaucoma, and cataracts. Services dealing with emotional concerns were wide ranging, but did not have depth or continuity. They were severely fragmented. Social programs to meet the needs of the well elderly were abundant. However, services were

lacking for the frail elderly in the areas of day care and respite care.

Availability of Service

Most services are available to the Food and Fellowship participants with a need. Some exceptions were identified. In the physical health area, not all services or educational information were offered in all locations. Scheduling was inadequate. The major deficiency was in the area of emotional health needs. Several different groups offered some help with these problems; but, these programs are not: (1) specifically for the elderly; (2) held on a regular basis; (3) effectively publicized; or (4) coordinated. The services in the area of social well-being did reach a great many people in the target group because outreach was conducted county-wide and social services and activities were numerous and varied.

The one serious gap was in the area of housing. There was not sufficient housing to accommodate all those in need. A stop-gap measure is a renters' service, which is offered to Food and Fellowship participants by the Office on Aging.

Efficiency and Effectiveness

Concerning delivery of the physical, emotional, and social needs of the target population in an efficient and effective manner, at congregate settings several problems

surfaced. Physical needs can best be addressed where the elderly congregate, which is basically at the eleven Food and Fellowship sites. Many physical needs were met at these locations; and, many other physical needs still need to be met. Services for emotional concerns were not coordinated for the target group either in the community or the sites. It appears that these needs, too, could be more efficiently and effectively dealt with at the Food and Fellowship sites, at least in an introductory manner. Many social needs were handled at the congregate sites. However, older persons still must go to certain service providers for help. This is an inconvenience to the elderly. The solution to housing problems is beyond the scope of this project.

CHAPTER IV CLOSING THE GAPS

In the last chapter, the physical, emotional, and social needs of older people were identified. This was followed by a comparison of the needs of elderly people and what is being done to meet the needs of the target population in congregate settings in Sheboygan County. The services for older residents of the county were analyzed according to three criteria: (1) the range of services available to meet the identified needs; (2) the availability of services to all of the target group who want them; and (3) the efficiency and the effectiveness of the services being delivered. The outcome of that analysis was that several gaps existed in prevention services in the county.

In this chapter, I am going to describe an attempt by the Office on Aging to close the gaps in the existing services for the target population who attend Sheboygan County Food and Fellowship sites. This effort is the development of a Wellness Services and Education Model Program. In my opinion, this is one approach to close the existing gaps.

The Wellness Services and Education Model Program is designed to provide both a variety of direct services for the elderly and education programs to inform them about

self-care and about other services available to them. It calls for introducing a wide array of services and programs, offered by local service providers, at eleven locations throughout Sheboygan County. The model is geared to be accepted by both the target elderly and the community as a whole.

The model program consists of six characteristics. In the following section, I will discuss the model characteristics, activities, and the rational for them.

1. The program requires the elderly to make a conscious decision to participate. The elderly must choose to come to one of the Food and Fellowship sites and must choose to participate in the screenings, services, and programs. The model recognizes that the individual's behavior is the key to health promotion and disease prevention. The wellness program features self-help because the literature indicated that the individual can do more for his own well-being than any other force. The emphasis is on the individual who must take charge of his/her own health. The model provides assistance to the individual in the form of screenings, information, and services; but, the responsibility rests firmly on the shoulders of the individual to take the necessary steps to modify his/her behavior.

2. The program consists of periodic screenings, health education and information about health services. The plan calls for a yearly health fair which features screenings

recommended for older persons, consultation with public health nurses, and health information all available in one location on a single day. The purpose of this activity is to point up the importance of a yearly check-up and also to expose the elderly to a myriad of information that may be of value to them. (see appendix III). The health fair is coordinated with health education and information about health services which are offered at the Food and Fellowship sites. (see appendix I).

Prior to the wellness plan, there was no coordination between the health fair and programming at the Food and Fellowship sites. The plan promotes coordination. It calls for promoting the exhibits before the fair in anticipation of stimulating interest in them. Also, it is logical for the nurse, who see clients at the health fair, to follow up on those persons needing more attention by seeing them at the Food and Fellowship sites. Without this follow up, the health fair nurse counseling is missing a vital component; and, if the nurse follows up by making several home visits instead of making one visit to the Food and Fellowship site, use of resources would not be maximized. Another possible benefit of coordination is that the nurse will become more involved at the sites and will make program suggestions based on her perceived needs of her clients.

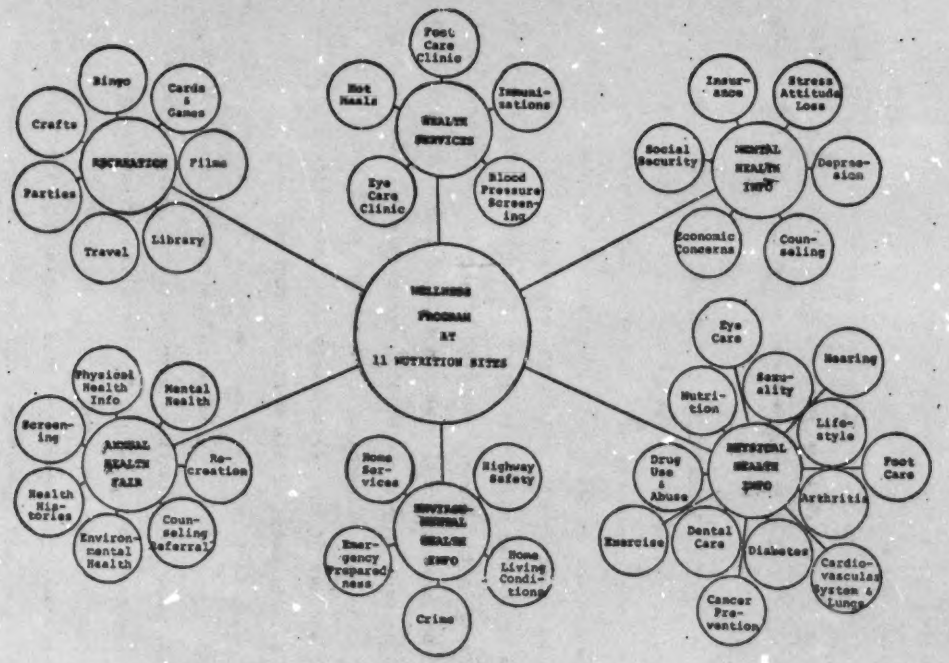
Specific screenings chosen and subject matter covered are

based on a review of the literature. The model considers the tentative findings of biological scientists, psychologists, and sociologists regarding their recommendations to enhance the quality of later life.

3. It stresses breadth rather than depth of services. All subjects identified in the previous chapter to have value to the elderly are included in the model program with recommended frequency (appendix I) and a timetable for implementation (appendix II). The subjects are grouped according to the wellness diagram (see page 57). It should be noted that the diagram includes both the existing services and those services that have not been available in the past, but will now be offered.

Subjects not previously covered which include general health assessments (life-styles), sexuality, dental care, eye care, and mental health issues have been added to the list of subjects to be covered. Another deficiency noted was the programs were often offered sporadically. The wellness plan deals with this problem by listing the frequency that each program should be offered.

Since elderly people are heterogeneous and have different physical, emotional, and social needs, our aim is to expose them to the whole range of wellness services and information and let them choose what is of value to them. Usually, an introduction to the subject is all they will


WELLNESS PROGRAM AT 11 NUTRITION SITES
RECREATION
Bingo
Cards & Games
Films
Library
Travel
Parties
Crafts
HEALTH SERVICES
Foot Care Clinic
Immunizations
Blood Pressure Screening
Eye Care Clinic
Hot Meals
MENTAL HEALTH INFO
Insurance
Stress Attitude Loss
Depression
Counseling
Economic Concerns
Social Security
PHYSICAL HEALTH INFO
Eye Care
Hearing
Sexuality
Lifestyle
Foot Care
Arthritis
Cardiovascular System & Lungs
Diabetes
Dental Care
Cancer Prevention
Exercise
Drug Use & Abuse
Nutrition
ENVIRONMENTAL HEALTH INFO
Highway Safety
Home Living Conditions
Crime
Emergency Preparedness
Home Services
ANNUAL HEALTH FAIR
Mental Health
Recreation
Counseling Referral
Environmental Health
Health Histories
Screening
Physical Health Info

tolerate. If a topic is approached in depth, many will have no interest, some will lose interest, and others will actually walk out. Therefore, our objective is to introduce them to the material and only offer it in greater depth if we determine that they want more information on a particular subject.

4. Activities will involve a variety of teaching methods. The model recommends varying the teaching methodology. The approaches will include brief lectures by experts, presentations by peers and site managers, quizzes, charts, posters, brochures, newsletters, games, and audio-visuals. Some activities will occur prior to the meal; others will be conducted after lunch. Whenever possible, the information will be presented orally and in printed form. All information will be kept simple and brief. Presenters will be advised as to the best methodology to reach the participants. Periodic surveys of the participants will be conducted to monitor the effectiveness of the wellness program.

Many factors were considered to determine how information should be presented. Because information has been offered at the Food and Fellowship sites over the past six years, we have been able to identify effective and ineffective teaching methods. We know we are dealing with a variety of old people. Each group includes people who cannot hear well, cannot see well, have short attention spans, and have had

little formal education. To supplement our first-hand knowledge, we have also read the literature regarding teaching the aged. See Hellburg's guidelines on page 29. Based on this information, we feel that our best approach is a varied one.

5. It features a decentralized delivery system coordinated with meal service. The model recommends: (a) combining information and services at a single location, and (b) having several decentralized sites located throughout the county in areas of high concentration of older persons.

Programs will be offered at eleven Food and Fellowship sites located throughout Sheboygan County. Health services and wellness educational activities will take place either directly before or after the meal, which is served at noon. Names of the sites, their locations, and days of operation are listed below:

St Peter Claver Church 1444 S. 11th Street Sheboygan	Monday through Friday
St. John's United Church of Christ 1248 Lincoln Avenue Sheboygan	Monday through Friday
Senior Citizens Center 621 S. Water Street Sheboygan	Monday through Friday
Municipal Building 375 Buffalo Street Sheboygan Falls	Monday through Friday

37-680 O—84——16

Fairgrounds Fairview Drive Plymouth	Monday through Friday
Senior Citizens Center Siefert Street Adell	Monday through Friday
St. John's United Church of Christ First Street and Random Lake Road Random Lake	Tuesday and Thursday
Senior Citizens Center 1110 S. Wisconsin Drive Howards Grove	Tuesday and Thursday
DeSmidt's Restaurant 115 S. Main Street Cedar Grove	Monday and Thursday
Village Hall First Street and Milwaukee Avenue Cascade	Friday
Knotty Pine Limited Restaurant 941 Center Avenue Oostburg	Wednesday

Strong arguments are made to provide the broad spectrum of services and information at a single location. The Surgeon General stresses delivering health promotion services to the elderly in one location and the Administration on Aging suggests creating focal points for elderly services where information and services can be delivered.

Having several decentralized sites located throughout the county is mandated by the Administration on Aging for the Nutrition Project for the Elderly. Administration on

Aging instructs their nutrition project grantees to locate meal sites in areas of high concentration of low-income older persons and to provide hot meals and supportive services to the elderly in those settings.[39] Since the elderly are congregating on a regular basis for a hot noon meal and supportive services at eleven locations throughout Sheboygan County, it seems appropriate to expand on these services and activities and offer a complete Wellness Services and Education Program in these facilities. Several factors favor this approach: (a) the meal serves as a catalyst. It brings the people to the site so that other services may be offered; (b) the elderly have access to the sites located in their community. Many are able to walk to the site and those unable to walk can be bused to the site; and (c) we feel that learning is more apt to take place and assistance accepted if older adults are at ease in the surroundings. At the sites, the participants are familiar with the atmosphere, they know the system, and they know who to ask for service.

It would be easier for the providers if all the people were bused directly to them, or to one central location instead of offering services at eleven places. However, the first concern of the Office on Aging is the participants, and we are attempting to make it as convenient as possible for those in need at attain help.

Also, I do not wish to imply that all services will take place at the Food and Fellowship sites. The plan calls for covering all physical, emotional, and social needs at these locations in an introductory manner. In-depth services will be conducted in other locations. For example, in-depth classes for arthritis and diabetes will be held at local hospitals, but arthritics and diabetics will learn about the hospital classes at the sites, and transportation to the hospitals for the classes will be provided.

The wellness model also calls for coordinating programs for all mental health issues that affect people in later life and offering information at the sites. This area was identified as a service gap and every effort will be made to coordinate the services which are now fragmented in the community.

6. It is directed by the Sheboygan County Office on Aging. The Office on Aging will serve as the control center for the complete wellness model. The department is responsible for the Health Fair, the Food and Fellowship sites, and information and referral for the elderly. Therefore, the staff will plan, implement, and coordinate the wellness program. The staff will contact resources, schedule speakers and activities, and keep the sites stocked with appropriate supplies. It is the staff's responsibility to adhere to the timetable. Scheduling will be handled by one staff person.

The Office on Aging played a role in attempting to close two gaps in service for the frail elderly--adult day care and respite care. These services will be part of the plan, because in 1980, pilot projects for both adult day care and respite care will be undertaken by community agencies at the request of the Office on Aging. These programs will be promoted at the Food and Fellowship sites.

The Sheboygan County Office on Aging with the guidance of the Sheboygan County Aging Unit has the overall responsibility of identifying the needs of older persons and coordinating services to meet those needs. This agency is recognized by all community groups as the focal point for information for the elderly. It has a proven record of success in being responsive to the elderly's opinions and needs, and receives support in those efforts from a myriad of community groups, both, in the public and private sector.

Since this agency has a competent staff capable of carrying out the wellness plan, the two procedural gaps will be eliminated. They are: (1) that programs were not held at all the Food and Fellowship sites; and (2) many programs were held sporadically.

Unresolved Issues

Preretirement planning was mentioned in an earlier chapter as a program that had value to a successful adjustment to retirement. Since it was not aimed at our target

population, it will not be part of the wellness plan; although the Office on Aging will attempt to implement a coordinated preretirement program in the future.

The only issue that has not been addressed is the issue of housing. In the last chapter, it was noted that issue was beyond the scope of the wellness plan. However, the Office on Aging will be expressing that need and will be seeking a solution to the housing problem.

Inter-Agency Relationships

~~The wellness program is dependent on the continuation and strengthening of the Office on Aging's existing support systems.~~ Hasenfeld lists four elements in the agency's environment that provide it with the resources necessary to attain its service and maintenance objectives.[40] I will list each of his elements and relate it to the wellness program in Sheboygan County.

1. Clients or consumers of its service

Some of the target group currently participate in the existing program. An outreach effort is conducted to recruit the target population. It includes: (a) referrals by other agencies; (b) information about the service in the news media; (c) in home visits to the isolated and widowed elderly; and (4) testimonials from those using the service.

2. Fiscal, manpower, technical, and other resouces essential to the goal-oriented performance .

The Office on Aging receives funds from federal, state, and county government. The agency operates some programs such as the nutrition program, transportation, information and referral, and chore service; and contracts with the Visiting Nurses Association, Mobile Meals, Inc., the Sheboygan Public Schools, and the Y.M.C.A. for other programs. The contracts provide a valuable resource link for the wellness model. Several experts in the field of disease prevention and health promotion helped plan the model and reviewed it, and they have indicated a continuing interest. Local health professionals are available and willing to assist in implementing various aspects of the program.

3. Complementary or supportive services without which an agency's services would be unattainable, inadequate, or ineffective.

The wellness model is predicated on the assumption that all areas that impact on the well-being of the target population will be introduced at the Food and Fellowship sites. Through this procedure, a relationship is established between the Office on Aging and all service providers for the elderly participants. The agency employs an information and referral specialist, and Food and Fellowship participants with unmet needs are given prompt referrals to appropriate agencies.

4. Support or recognition from regulatory and auspice-providing bodies which give the program its authority or mandate

The Food and Fellowship program has many masters. It is based on the federally-funded nutrition program for the elderly and therefore, those regulations must be followed. A significant recommendation of those regulations is that there should be an advisory council comprised of recipients of service and community persons. The county operated Food and Fellowship Project Council is comprised of two members from each of the eleven sites, a member of the Social Services Board, a member of the Commission on Aging, a Social Security Administration field worker, and a Department of Social Services adult intake worker. This group's input was sought for the development and implementation of the wellness plan and they will monitor its effectiveness. Since policy for the Food and Fellowship program is set by the Social Services Board and advice is sought from the Commission on Aging, both groups were asked to react to the plan. Because the program is operated by the County, county policy and procedure must be followed. Being a county agency provides a degree of legitimation. This is enhanced by the social support from community groups involved with the program and a satisfied client group.

CHAPTER V SUMMARY

To summarize, the Surgeon General has told us that services and programs targeted at the elderly can help prevent deterioration, avoid needless institutionalization, and maintain functional independence.

This paper has recommended a Wellness Services and Education Model Program as one approach to attain these goals for the elderly target population in Sheboygan County. The wellness program is designed to provide a variety of direct services for the elderly and education programs to inform them about self-care and about other services available to them. The program is to be conducted at eleven Food and Fellowship sites located throughout the county. The only exception to this is the location of the county-wide health fair which is held at a single location once a year. This exception is made because of resource limitations. There is not sufficient manpower to provide a battery of screenings at eleven locations, nor are all of the eleven physical facilities adequate for screening procedures.

The model program is based on the following premises: (a) it advocates self-care as a key element to maintain elderly well-being; (b) it recommends periodic screenings of

specific body functions, health education, and information about health services; (c) it stresses a broad range of services instead of depth of services; (d) it suggests a variety of teaching methods; (e) it calls for a decentralized delivery system; and (f) it is directed by a central local agency.

This particular approach was chosen following a review of the literature, discussion with experts in the field of health promotion and disease prevention, and experience with past health promotion and disease prevention efforts in Sheboygan County. Elements considered were the physical, emotional, and social needs of older persons; how to respond to the identified needs; and what gaps existed in Sheboygan County between the actual needs of the elderly and services and programs available to the target population, who attend Food and Fellowship sites.

Now that a Wellness Services and Education Model Program has been selected for Sheboygan County's Food and Fellowship sites and implementation is taking place, an evaluation of the model program is being formulated. A process evaluation is being developed, which will be followed by an outcome evaluation. Evaluation information is found in appendix VI.

In conclusion, a model program aimed to promote health and prevent disease in the elderly has been designed for Sheboygan County residents who participate in congregate programs. It is intended that older persons participating in the annual health fair and in the program which features health services and educational programs offered at eleven Food and Fellowship sites, will maintain and enhance their well-being; so indeed, later life will be a physically and emotionally healthy and pleasant time of life with few physical and mental limitations.

ENDNOTES

[1]Julius B. Richmond, MD, Healthy People, The Surgeon General's Report on Health Promotion and Disease Prevention (Washington, D.C.: DHEW (PHS) Publication No. 79-55071), p. 71.

[2]Ibid.

[3]Oregon State University, Guide to Effective Project Operations, The Nutrition Program for the Elderly, April, 1973, (Washington, D.C.: Administration on Aging, DHEW), p. 4.

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[5]Ibid.

[6]Wisconsin Department of Health and Social Services, The Needs of Wisconsin's Older People, December 1971.

[7]Robert N. Butler and Myrna I. Lewis, Aging and Mental Health (St. Louis: The C.V. Mosby Co., 1977), p. 17.

[8]Introduction by Joseph A. Califano, Jr., Healthy People, The Surgeon General's Report on Health Promotion and Disease Prevention (Washington, D.C.: DHEW (PHS) Publication No. 79-55071), p. viii.

[9]U.S., Department of Health, Education and Welfare, Guide to Medical Self-Care and Self-Help Groups for the Elderly. (Washington, D.C.: DHEW (PH-NIH) Publication No. 80-1687), p. 3.

[10]Ky Lorenz and Devra Davis, "The Health Promotion Organization-a Practical Intervention Designed to Promote Healthy Living," Public Health Reports, September, October 1978, pp. 446-455.

[11]Julius B. Richmond, MD, Healthy People, The Surgeon General's Report on Health Promotion and Disease Prevention (Washington, D.C.: DHEW (PHS) Publication No. 79-55071), p. 155.

[12]Melanie K. Wieland, 1980 Older Americans Health Fair Program (Bethesda, MD: National Health Screening Council for Volunteer Organizations Inc., 1980), p. 2.

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[17]Nathan W. Schock, "The Physiology of Aging," in Gerontology, A Book of Readings, ed. Clyde B. Vedder, Ph. D., (Springfield, IL: Charles C. Thomas Publishers, 1971), pp. 264-265.

[18]Ruth B. Weg, "Changing Physiology of Aging: Normal and Pathological," in Aging Scientific Perspectives and Social Issues, ed. Diana S. Woodruff and James E. Birrens (New York: F. Van Nostrand Co., 1975), pp. 229-256.

[19]Ibid.

[20]Robert N. Butler and Myrna I. Lewis, Aging and Mental Health (St. Louis: The C.V. Mosby Co., 1977), p. 21.

[21]Ruth B. Weg, "Changing Physiology of Aging: Normal and Pathological," in Aging Scientific Perspectives and Social Issues, ed. Diana S. Woodruff and James E. Birrins (New York: F. Van Nostrand Co., 1975), p. 250.

[22]Ibid.

[23]Ibid.

[24]Robert N. Butler and Myrna I. Lewis, Aging and Mental Health (St. Louis: The C.V. Mosby Co., 1977), p. 37.

[25]Louis Lowy, Social Work with the Aging (New York: Harper & Row Publishers, 1979), p. 195.

[26]Julius B. Richmond, MD, "Health Promotion and Disease Prevention in Old Age," Aging, May-June 1979, p. 11.

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[30]Ibid., p. 131.

[31]Ibid., p. 132.

[32]Julius B. Richmond, MD, Healthy People, The Surgeon General's Report on Health Promotion and Disease Prevention (Washington, D.C.: DHEW (PHS) Publication No. 79-55071), p. 71.

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[36]Louis Lowy, Social Work with the Aging (New York: Harper & Row Publishers, 1979), p. 163.

[37]Jeanne C. Hellburg, "The Teaching of Aged Adults," Journal of Gerontological Nursing 2 (May-June 1976): 18.

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[39]Oregon State University, Guide to Effective Project Operations, The Nutrition Program for the Elderly, April, 1973, (Washington, D.C.: Administration on Aging, DHEW), p. 16.

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APPENDIX I

PROGRAMS	FREQUENCY	PROVIDER	LOCATION	Comments, Additions Ranking 3 = very important 2 = important 1 = unimportant
BLOOD PRESSURE:				
Importance of blood pressure reading	yearly	public health nurse	each site	
Teach self-administered blood pressure reading	quarterly	public health nurse	each site	
Blood pressure monitoring (in conjunction with counseling)	quarterly	public health nurse	each site	
EXERCISE				
Moderate exercises prior to real-increasing as capability increases	daily	site manager-volunteers training program provided	each site	
Value of exercises	quarterly	M.D. Y.M.C.A. staff	each site	
NUTRITION				
Nutrition Quiz on variety of topics	daily	site manager or volunteers (trained by dietitian)	each site	
Nutrition topic and counseling	bi-monthly	dietitian	each site	
DRUG USE AND ABUSE				
Discussion over the counter, generic, combination of drug use, update prescriptions, alcoholism, over use of drugs	yearly	pharmacist Tennessee Institute instructors with students	each site	

PROGRAMS	FREQUENCY	PROVIDER	LOCATION	Comments, Additions Ranking 3 - very important 2 - important 1 - unimportant
DENTAL CARE Proper mouth care-teeth, gums, dentures	yearly	dentists dental hygenists dental wives	each site	
ARTHRITIS AND DIABETES Explanation of hospital prograss	yearly-ongoing	hospital staff site managers-keep group informed when hospital program is coming up	each site	
MENTAL HEALTH Isolation, withdrawal, loss, depression	yearly	psychiatrist Mental Health Center Mental Health Association	each site	
Stress management	yearly	"	each site	
Death and dying	yearly	"	each site	
Counseling available	as needed	"	each site	
Attitudes toward aging, control over behavior	as needed	"	each site	
FOOT CARE Proper foot care	yearly	podiatrist public health nurse	each site	
Foot clinic	yearly	podiatrist Visiting Nurses Assn.	four sites	

PROGRAMS	FREQUENCY	PROVIDER	LOCATION	Comments, Additions Ranking 3 - very important 2 - important 1 - unimportant
HIGHWAY SAFETY				
Quiz for safe driving speed, safety belts, rules of road, eye tests	monthly	site managers (trained by Highway Safety)	each site	
Defensive driving course	yearly	Technical Institute	one site	
EMERGENCY PREPAREDNESS				
Vial of Life	always available	distributed by site manager	each site	
Checklist for emergency	always available	distributed by site manager	each site	
Telephone reassurance	always available	distributed by site manager	each site	
EYE CARE				
Explanation of glaucoma cataracts, need for testing	yearly	ophthalmologist optometrist Technical Institute instructors & students in optical assistant program	each site	
Eye glass repair clinic	yearly	Technical Institute instructor & students	six sites	

PROGRAMS	FREQUENCY	PROVIDER	LOCATION	Comments, Additions Ranking 3 - very important 2 - important 1 - unimportant
CANCER PREVENTION				
Breast self-examination	yearly	public health nurse representative from Cancer Society	each site	
Discussion how to prevent cancer, check-up, smoking, warning signals, etc.	yearly	representative from Cancer Society	each site	
Stop smoking self-help group	ongoing	representative from Cancer Society	where 5 or more smokers congregate	
CARDIOVASCULAR SYSTEM AND LUNGS				
Stroke-importance of diet, exercise, etc.	yearly	N.D. respiratory therapist physical therapist	each site	
No smoking (could be incorporated with other areas)				
ENVIRONMENTAL				
Home safety	ongoing	site managers & volunteers at sites	each site	
Water supply Pollution Nuclear concerns	yearly	public health department	each site	
Chore service	ongoing	site manager	each site	
Home care services	ongoing	site manager	each site	
Mobile meals VNA Homemaker	yearly	Visiting Nurses Assn.	each site	

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PROGRAMS	FREQUENCY	PROVIDER	LOCATION	Comments, Additions Ranking 3 - very important 2 - important 1 - unimportant
WELLNESS				
Life-styles, attitudes, counseling and appropriate referrals and follow-up	yearly	M.D. public health nurse	each site	
Flu shots	yearly	public health nurse	each site	
SOCIAL SECURITY INSURANCE				
Social Security and Medicare-how to use the system, fill out forms, etc.	bi-monthly	Social Security representative	each site	
Insurance information	yearly	insurance underwriters	each site	
Insurance counseling	ongoing by appointment	insurance underwriters	each site	
LIBRARY AND RECREATION INFORMATION				
Library programs include wellness books & magazine articles	twice monthly	Wood Public Library	two sites	
"	monthly	Random Lake & Falls libraries	two sites	
"	monthly	site managers-hand out materials-library's in those areas if possible	seven sites	
Community events	ongoing	site managers	each site	

PROGRAMS	FREQUENCY	PROVIDER	LOCATION	Comments, Additions Ranking 3 - very important 2 - important 1 - unimportant
ECONOMIC CONCERNS				
Financial concerns	yearly	U.W. Extension	each site	
Consumerism	monthly	Technical Institute	each site	
understanding the health industry				
understanding the funeral industry				
how to use the health system				
Employment	yearly	Job Service	each site	
List of employment	ongoing	site managers	each site	
SEXUALITY				
Introduction of subject	yearly	M.D. sex therapist	each site	
HEARING				
Discussion of hearing	yearly	audiologist	each site	

APPENDIX II

WELLNESS PROGRAM	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sep.	Oct.	Nov.	Dec.
PHYSICAL HEALTH												
Sexuality												
Discuss ways to present this subject with physicians, sex therapist, or other health professionals	X											
Implement program						X						
Nutrition												
Monitor current program	X	X	X	X	X	X	X	X	X	X	X	X
Diabetes												
Check supply of information at sites and keep current	X		X		X		X		X		X	
Monitor program								X				
Cancer Prevention												
Breast self-examination, discuss with public health nurses	X											
Conduct breast self-examination program				X								
Arrange for program on warning signals, prevention, and stop-smoking group		X										
Conduct program on cancer prevention					X	X						
Stop smoking self-help group, if there are 5 or more people										X		
Dental Care												
Talk with dentists to determine how to approach			X									
Implement sessions							X	X	X			
Hearing												
Discuss ways to bring information to group with audiologist		X										
Implement program									X			

WELLNESS PROGRAM	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sep.	Oct.	Nov.	Dec.
PHYSICAL HEALTH (cont.)												
Exercise												
Monitor daily exercise	X	X	X	X	X	X	X	X	X	X	X	X
Y.M.C.A.-Seniors on the Move-monitor		X		X						X		
Discuss exercise with physicians	X											
Life-style												
Discuss with public health nurses and physicians	X											
Implement program		X										
Arthritis												
Check supply of information at sites, keep current	X		X		X		X		X		X	
Monitor program												
Foot Care												
Discuss how to get good information to people with podiatrist and public health nurses			X									
Implement program							X					
Cardio-vascular System and Lungs												
Discuss with physician	X											
Get and provide literature from Heart and Lung Association		X										
Implement program				X								
Drug Use and Abuse												
Discuss with Lakeshore Technical Institute instructors	X											
Implement sessions			X	X	X							
Eye Care												
Discuss with Lakeshore Technical Institute instructors	X											
Conduct sessions			X	X	X							

WELLNESS PROGRAM	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sep.	Oct.	Nov.	Dec.
MENTAL HEALTH												
Stress, Attitude, Loss												
Meet with psychiatrist		X										
Mental Health Association / Mental Health Clinic			X									
Depression, Loneliness												
Meet with psychiatrist		X										
Mental Health Association / Mental Health Clinic			X									
Counseling												
Monitor program			X			X						
Economic Concerns												
Review total program with presenter	X											
Monitor program				X					X			
Social Security												
Review total program with presenter	X											
Monitor program				X		X			X			

WELLNESS PROGRAM	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sep.	Oct.	Nov.	Dec.
HEALTH SERVICES												
Eye Care Clinic												
Talk with Lakeshore Technical Institute about setting up	X											
Implement clinic			X									
Hot Meals												
Monitor	X	X	X	X	X	X	X	X	X	X	X	X
Foot Care Clinic												
Talk with podiatrist and Visiting Nurses Association about setting up			X	X								
Implement clinic									X			
Immunizations												
Review with public health nurses	X											
Implement program								X				
Blood Pressure Screening												
Discuss with public health nurses	X											
Monitor program			X						X			

WELLNESS PROGRAM	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sep.	Oct.	Nov.	Dec.
ENVIRONMENTAL HEALTH INFORMATION												
Highway Safety												
Talk with local committee						X						
Implement program									X			
Home Living Conditions												
Monitor home safety information at sites	X		X		X		X		X		X	
Water Supply, Pollution, Other Environmental Problems												
Discuss with city and county health departments	X											
Implement program					X							
Chore service - monitor program	X		X		X		X		X		X	
Home Services												
Home-care services including visiting nurses, mobile meals, and homemaker-monitor program		X								X		
Emergency Preparedness												
Vial of Life-												
Check list for emergency-												
Telephone reassurance-monitor program	X		X		X		X		X		X	
Emergency Procedures												
Heimlich and CPR techniques	X											
What to do in emergency		X										
Monitor			X									

APPENDIX III

ARE YOU GOING TO HAVE THE BLOOD TEST?

IF SO, A COMPLETE MEAL SHOULD BE EATEN 2 HOURS PRIOR TO THE BLOOD TEST.

IF YOU ARE ATTENDING THE HEALTH FAIR IN THE MORNING, EAT:

BREAKFAST

1 cup fruit juice
1 serving cereal with milk & sugar
toast with corn oil margarine & jelly
1 cup low-fat milk

IF YOU ARE ATTENDING THE HEALTH FAIR IN THE AFTERNOON, EAT:

LUNCH

Lean meat (poultry or fish)
Potato or substitute (noodles, rice, etc.)
1 vegetable
Salad and/or fruit
Low-fat dessert
Corn oil margarine
1 cup low-fat milk
Bread

FOODS TO AVOID BEFORE THE BLOOD TEST: BUTTER, EGG YOLK, WHOLE MILK, LIVER, PORK, ICE CREAM.

THE SHEBOYGAN COUNTY HEALTH FAIR IS SPONSORED BY

THE SHEBOYGAN COUNTY OFFICE ON AGING

CONTRIBUTING AGENCIES & GROUPS

AMERICAN CANCER SOCIETY
AMERICAN KIDNEY FOUNDATION
AMERICAN RED CROSS
ANN MC COMIS - VOLUNTEER COORDINATOR
BOY SCOUTS OF AMERICA
CITY OF SHEBOYGAN FALLS
COMMUNITY VOLUNTEERS
LAKESHORE TECHNICAL INSTITUTE
MEAD PUBLIC LIBRARY
MEMORIAL HOSPITAL
MENTAL HEALTH ASSOCIATION
RICHARDSON LUMBER COMPANY
ST. NICHOLAS HOSPITAL
SHEBOYGAN CLINIC
SHEBOYGAN COUNTY COMMISSION ON AGING
SHEBOYGAN COUNTY DENTAL AUXILIARY
SHEBOYGAN COUNTY DENTAL SOCIETY
SHEBOYGAN COUNTY INSURANCE UNDERWRITERS
SHEBOYGAN COUNTY NURSES OFFICE
SHEBOYGAN COUNTY OPTOMETRIC AUXILIARY
SHEBOYGAN COUNTY PHARMACISTS ASSOCIATION
SHEBOYGAN COUNTY PHARMACISTS AUXILIARY
SHEBOYGAN COUNTY PODIATRISTS
SHEBOYGAN COUNTY YMCA
SHEBOYGAN LIONS CLUB
SHEBOYGAN SERVICE CLUB
SHEBOYGAN HEALTH DEPARTMENT
SOCIAL SECURITY ADMINISTRATION
UNIFIED BOARD
UNIVERSITY OF WISCONSIN LABORATORIES
VISITING NURSE ASSOCIATION
WISCONSIN HIGHWAY SAFETY DEPARTMENT
WISCONSIN LUNG ASSOCIATION

APPENDIX IV

Your Lifestyle Profile

- Indicate by circling or checking only the signs that apply to you.
- The plus (+) and minus (−) signs next to some numbers indicate more than (+) and less than (−).

Exercise

Amount of physical effort expended during the workday mostly

Many physical, walking, housework — Desk work

Participation in physical activities — (swing, golf, swimming, etc.) (lawn mowing, gardening, etc.)?

Daily — Weekly — Seldom

Participation in a vigorous exercise program?

3 times Weekly — Weekly — Seldom

Average miles walked or jogged per day?

1+ — −1 — None

Flights of stairs climbed per day?

10+ — −10

Nutrition

Are you overweight?

No — 5 to 19 lbs. — 20+ lbs.

Do you eat a wide variety of foods — something from each of the following five food groups: (1) meat, fish, poultry, dried legumes, eggs or nuts; (2) milk or milk products; (3) bread or cereals; (4) fruits; (5) vegetables?

Each day — 3 times Weekly

Alcohol

Average no. of bottles (12 oz.) of beer per week?

0 to 7 — 8 to 15 — 16+

Average no. hard liquor (1½ oz.) drinks per week?

0 to 7 — 8 to 15 — 16+

Average no. of glasses (5 oz.) of wine or cider per week?

0 to 7 — 8 to 15 — 16+

Total no. of drinks per week, including beer, liquor, and wine?

0 to 7 — 8 to 15 — 16+

Sub totals			

Drugs

Do you take drugs illegally?

No — Yes

Do you consume alcoholic beverages together with certain drugs (tranquilizers, barbiturates, analystamines or illegal drugs)?

No — Yes

Do you use pain-killers improperly or excessively?

No — Yes

Tobacco

Cigarettes smoked per day?

None — −10 — 10+

Cigars smoked per day?

None — −5 — 5+

Pipe tobacco pouches per week?

None — −2 — 2+

Personal Health

Do you experience periods of depression?

Seldom — Occasionally — Frequently

Does anxiety interfere with your daily activities?

No — Occasionally — Frequently

Do you get enough satisfying sleep?

Yes — No

Are you aware of the causes and danger, of VD?

Yes — No

Breast self-examination? (If not applicable, do not score.)

Monthly — Occasionally

Sub totals			

Road and Water Safety

Mileage per year as driver or passenger?

−10,000 — 10,000+

Do you often exceed the speed limit?

No — by 10 mph+ — by 20mph+

Do you wear a seatbelt?

Always — Occasionally — Never

Do you drive a motorcycle, moped or snowmobile?

No — Yes

If yes to the above, do you always wear a regulation safety helmet?

Yes — No

Do you ever drive under the influence of alcohol?

Never — Occasionally

Do you ever drive when your ability may be affected by drugs?

Never — Occasionally

Are you aware of water safety rules?

Yes — No

If you participate in water sports or boating, do you wear a life jacket? (If not applicable, do not score.)

Yes — No

General

Average time watching TV per day (in hours)?

0 to 1 — 1 to 4 — 4+

Are you familiar with first-aid procedures?

Yes — No

Do you ever smoke in bed?

No — Occasionally — Yes

Do you always make use of clothing and equipment provided for your safety at work? (If not applicable, do not score.)

Yes — Occasionally — No

Sub totals			

Scoring Section

Count total number of ○ ▽ ☒ 1 point for each ○ 3 points for each ▽ 5 points for each ☒

Your total score

APPENDIX V

Food And Fellowship

Menu and Programming
April 29-May 5

Please make reservations in person at the sites during program hours. For more information concerning "Food and Fellowship," Stagecoach schedules, and other services call the Sheboygan County Office on Aging (459-3095).

NEW REGISTRANTS CALL A DAY IN ADVANCE
Between Hours of 8:30 to 9:30 a.m.

St. John's 1340 Lincoln Ave	Call: Evelyn Johnke, 457-7020 Meals served at noon
St. Peter Clover 1444 S. 15th St.	Call: Caroline Steffen, 453-8294 Meals served at noon
Senior Citizen Center 621 S. Water St.	Call: 459-3290 Meals served at 11:45 a.m.
Sheboygan Falls Municipal Building	Call: Julie Glancey, 467-2537 Meals served at 12:15 p.m.

Substitutions will be made if necessary

ST. NICHOLAS HOSPITAL DINNER MENU

TUESDAY — Braised beef tenderette, mashed potatoes with gravy, green and wax beans, tomato juice, chocolate cake, roll.

Programs: St. Peter Clover — Ceramics — 12:30 p.m.; St. John's — [redacted] — 11:15 a.m.; Sr. Center — Exercise with Kip — 11:30 a.m.; Falls — Film.

WEDNESDAY — Chop suey, buttered rice, molded fruit salad, gingerbread, roll.

Programs: St. Peter Clover — Bingo — 12:30 p.m.; St. John — Bingo — 12:30 p.m.; Sr. Center — "[redacted]" program presented by the Sheboygan Mayors Commission on Aging — Health subcommittee — 11:15 a.m.; Falls — Viola Eigendorf, member of legislative committee on Aging, "[redacted] — 11:45 a.m., Dartball [redacted]:45 p.m.

THURSDAY — Baked chicken, mashed potatoes, sliced carrots, fruit salad with honey dressing, tapioca pudding.

Programs: St. Peter Clover — Karen Soerens, LTI, "[redacted] — 12:30 p.m.; St. John — [redacted] Sr. Center — Karen Soerens, LTI, "Shopping Tips" — 11:15 a.m.; Falls — Film — 12:30 p.m.

FRIDAY — French fried fish with tartar sauce, baked potato, chopped broccoli, bean salad, cake square.

Programs: St. Peter Clover, St. John, Falls, Senior Center — games after meal.

MONDAY — Meatloaf, scalloped potatoes, green beans, shredded lettuce with dressing, sliced pears, cookie.

Programs: St. Peter Clover — Exercise with Jenna — 11:15 a.m. — Soups On — 12:30 p.m.; St. John — Kitchen Band — 11:15 a.m.; Library film with Carl "Agueda Martinez" — 12:30 p.m. — Ceramics — 1 p.m.; St. Center — Dartball — Sure Shots vs Adell at Sheboygan — 1 p.m.; Falls — Ceramics — 8 a.m.; Soups on — 12:45 p.m.

Bread, milk, and coffee served with all meals.

APPENDIX VI

THE PURPOSE OF THIS SURVEY IS TO FIND OUT HOW YOU FEEL ABOUT THE FOOD AND FELLOWSHIP PROGRAM. YOUR ANSWERS TO THE FOLLOWING QUESTIONS WILL BE STRICTLY ANONYMOUS (MEANING NO ONE WILL KNOW WHAT YOUR ANSWERS WERE). MANY QUESTIONS WILL DISCUSS TOPICS RELATED TO YOUR HEALTH NEEDS AND INFORMATION PROGRAMS BEING OFFERED AT YOUR SITE. THE ANSWERS YOU GIVE WILL HELP US PLAN FUTURE PROGRAM NEEDS. PLEASE ANSWER ALL QUESTIONS. THANK YOU!

A. FOOD AND FELLOWSHIP PROGRAM

1. ARE YOU SATISFIED WITH THE PROGRAMS BEING OFFERED AT THE SITE?

_____VERY SATISFIED _____SOMEWHAT SATISFIED _____NOT SATISFIED

2. HOW OFTEN DO YOU EAT AT THE SITE? _____WEEK _____MONTH

3. ARE YOU SATISFIED WITH THE FOOD PROGRAM BEING OFFERED AT THE SITE?

_____VERY SATISFIED _____SOMEWHAT SATISFIED _____NOT SATISFIED

4. WOULD YOU GO TO THE SITE IF THE MEALS WERE STOPPED?

_____YES _____NO

5. ARE YOU ACTIVE SOCIALLY AT THE SITE IN THE FELLOWSHIP PROGRAM? _____YES _____NO

6. DO YOU FIND THE INFORMATIVE PROGRAMS HELPFUL TO YOU?

_____YES _____NO

EXPLAIN_____

7. IN YOUR OVERALL OPINION, HOW WOULD YOU RATE THE INFORMATION PROGRAM TOPICS?

_____EXCELLENT _____SATISFACTORY _____POOR

8. THE FOLLOWING LIST OF TOPICS REPRESENT MANY ISSUES WHICH DEAL WITH HEALTH NEEDS. RESPOND TO THE LISTED TOPICS BELOW BY PUTTING A NUMBER WHICH MOST CLOSELY INDICATES HOW IMPORTANT THESE TOPICS ARE TO YOU. USE THE FOLLOWING SCALE TO SHOW YOUR OPINION ON EACH TOPIC:

1. MOST IMPORTANT
2. VERY IMPORTANT
3. IMPORTANT
4. LITTLE IMPORTANCE
5. NOT IMPORTANT

_____DEPRESSION	_____DIET	_____HOME SAFETY
_____LONELINESS	_____ARTHRITIS	_____HIGHWAY SAFETY
_____COUNSELING	_____FOOT CARE	_____WATER
_____STRESS	_____HEART	_____POLLUTION
_____NERVOUSNESS	_____LUNG PROBLEMS	_____HEALTH SERVICES
_____ECONOMIC CONCERNS	_____DIABETES	_____HOT MEALS
_____SOCIAL SECURITY	_____HIGH BLOOD PRESSURE	_____IMMUNIZATIONS
_____HUMAN SEXUALITY	_____EXERCISE	_____EMERGENCY NEEDS
_____LIFE-STYLE	_____RECREATION	_____EMERGENCY READING
_____INSURANCE	_____DENTAL CARE	_____SCREENING TESTS
_____CRIME	_____HEARING	_____CANCER PREVENTION
_____NUTRITION	_____EYE CARE	_____DRUG USE AND ABUSE

9. MANY OF THE TOPICS YOU HAVE JUST RESPONDED TO HAVE BEEN PRESENTED IN THE INFORMATION PROGRAM AT YOUR SITE. IN YOUR OPINION, HOW WELL WERE THEY PRESENTED?

_____VERY WELL _____SATISFACTORILY _____POORLY

10. WHICH INFORMATION TOPICS DID YOU FIND MOST HELPFUL TO YOU FROM THE LIST PROVIDED IN QUESTION #8. RATE IN ORDER OF IMPORTANCE WITH #1 BEING MOST IMPORTANT:

1._____ 3._____

2._____ 4._____

5._____

11. WOULD YOU LIKE TO SEE THE INFORMATION PROGRAM CONTINUED?

_____YES _____NO

12. ARE THERE ANY TOPICS OR ISSUES NOT LISTED WHICH YOU BELIEVE ARE IMPORTANT AND SHOULD BE ADDED TO THE PROGRAM?

_____ _____

_____ _____

EXPLAIN:_____

13. WHAT ARE REASONS WHY YOU BELIEVE THE FOOD AND FELLOWSHIP PROGRAM IS USEFUL TO YOU? (EXPLAIN)_____

_____

B. ANNUAL HEALTH FAIR

14. DO YOU GO TO THE HEALTH FAIR? _____YES _____NO

15. DO YOU FIND THE HEALTH FAIR AND INFORMATION GIVEN OF HELP TO YOU. _____YES _____NO

16. WHAT DO YOU LIKE BEST ABOUT THE HEALTH FAIR? (RANK THEM 1-7 USING EACH NUMBER ONCE, #1 IS MOST IMPORTANT.

_____ENVIRONMENTAL HEALTH INFORMATION
_____PHYSICAL HEALTH INFORMATION
_____MENTAL HEALTH INFORMATION
_____RECREATION/EXERCISE
_____SCREENING AND TESTING
_____HEALTH HISTORIES
_____COUNSELING AND REFERRALS

C. HEALTH CONCERNS

17. WHAT HEALTH PROBLEM CAUSES YOU GREATEST CONCERN?

(COMMENT)_____

18. WHEN WAS THE LAST TIME YOU VISTED A PHYSICIAN BECAUSE OF ILLNESS? _____MONTHS _____YEARS

19. WHEN WAS THE LAST TIME YOU HAD A COMPLETE PHYSICAL CHECK-UP? _____MONTHS _____YEARS

20. CONCERNING YOUR OWN HEALTH CONDITIONS, WHICH OF THE FOLLOWING BOTHERS YOU THE: (CHECK ONE)

	MOST	SOMETIMES	NOT AT ALL
A. EYE TROUBLE	____	____	____
B. EAR TROUBLE	____	____	____
C. TOOTH OR GUM PROBLEMS	____	____	____
D. SHORTNESS OF BREATH	____	____	____
E. PAIN IN CHEST	____	____	____
F. COUGHING	____	____	____
G. BLEEDING	____	____	____
H. HIGH BLOOD PRESSURE	____	____	____
I. SINUS PROBLEMS	____	____	____
J. ASTHMA	____	____	____
K. HAY FEVER	____	____	____
L. SWOLLEN JOINTS	____	____	____
M. BACK ACHE	____	____	____
N. SLEEPING PROBLEMS	____	____	____
O. IRRITABILITY	____	____	____
P. STOMACH PAINS	____	____	____
Q. KIDNEY PROBLEMS	____	____	____
R. BLADDER PROBLEMS	____	____	____
S. NERVOUSNESS	____	____	____
T. ARTHRITIS	____	____	____
U. RASH OR SKIN PROBLEMS	____	____	____
V. DEPRESSION (LOW SPIRITS)	____	____	____
W. HEADACHES	____	____	____
X. DRUG PROBLEMS	____	____	____
Y. OVER WEIGHT	____	____	____
Z. UNDER WEIGHT	____	____	____

THE FOLLOWING QUESTIONS WILL HELP US RESPOND TO YOUR NEEDS AND ASSIST US IN VIEWING THE INFORMATION. PLEASE RESPOND ACCORDINGLY.

21. HOW OLD ARE YOU? _____AGE

22. WHAT IS YOUR SEX? _____MALE _____FEMALE

23. WHAT IS, (OR WAS) YOUR OCCUPATION? _____

_____ FULL-TIME
_____ PART-TIME
_____ RETIRED

24. LAST YEAR OF COMPLETED EDUCATION?
(CIRCLE ONE) 1 2 3 4 5 6 7 8 9 10 11 12
COLLEGE POST GRADUATE

25. HOW FAR MUST YOU TRAVEL TO VISIT YOUR SITE?
_____BLOCKS _____MILES

26. HOW DO TRAVEL WHEN VISITING THE SITE?

_____OWN CAR _____RIDE WITH OTHER FRIENDS
_____WALK _____USE THE STAGECOACH
_____USE PUBLIC TRANSPORTATION
_____OTHER (EXPLAIN)_____

THANK YOU FOR YOUR HELP. THE INFORMATION YOU HAVE GIVEN WILL BE OF GREAT IMPORTANCE AND WILL ASSURE THE FOOD AND FELLOWSHIP PROGRAM IS DESIGNED TO MEET YOUR NEEDS AND INTERESTS.

37-680 O—84——18

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1983 Programs

PHYSICAL HEALTH INFO - Eye Care

Eye Care	Dr. D. King Aymond Sheboygan Clinic opthomologist
Eye Care	Dr. David Kisiolek private practice optometrist
Cataracts & Lens Implants	Dr. Christopher Larson private practice opthomologist

PHYSICAL HEALTH INFO - Nutrition

Nutrition Tips - Daily Sweetners Enrichment & Fortification of Foods Cholesterol, Saturated Fats and Triglycerides Vitamins A & C Fat vs. Water Soluble Vitamins Carbohydrates, Proteins & Fats Weight Control Food Safety & Sanitation Less Salt, Less Fat, Less Sugar Food Labels How to Get the Most for Your Food Dollar Basic 4	Site Managers/instructed by dietitian (one topic per month)
Weight Control - Weekly	Jean Pittner, Registered Dietitian
Dietary Counseling and The Fuss About Food Additives Tips on Weight Control A New Sweetner (NutraSweet)	Jean Pittner, Registered Dietitian (visits each site 3 times per year)
Nutritional Labeling	Karen Soerens, Home Economist, Adult Services, Lakeshore Technical Institute

PHYSICAL HEALTH INFO - Hearing

Hearing Problems	Dr. Frederic Tyszka Sheboygan Clinic audiologist
Hearing Problems	Suzanne Neumann Sheboygan Clinic audiologist
When a Hearing Aid Will Help	Jim Bohren certified hearing aid audiologist

PHYSICAL HEALTH INFO - Sexuality

Sexuality	Alice Maffongelli, R.N. Assistant Director of Nurses Heritage Nursing Center

1983 Programs

PHYSICAL HEALTH INFO - Foot Care

Foot Care	Dr. George Brett private practice podiatrist

PHYSICAL HEALTH INFO - Life Style

Staying Healthy	Dr. Stephen Poush Sheboygan Clinic Physician
Staying Healthy	Dr. Gregory Weisshaar Sheboygan Clinic Physician
Staying Healthy	Dr. Robert Willis Sheboygan Clinic Physician
Staying Healthy	Dr. Stephen Westcott Sheboygan Clinic Physician
Wellness	Pat Schroeder, Director Sheboygan Wellness Association

PHYSICAL HEALTH INFO - Exercise

Exercises - Daily	Site Participant Leaders
Film, "The Good Life"	Benefits of Exercise from Travelers Insurance Co.
Proper Use of Exercise Bikes	Donna Primozic, Exercise Leader, Sheboygan Y.M.C.A.

PHYSICAL HEALTH INFO - Cardio Vascular System & Lungs

Cardio Vascular Benefits of Exercise	John Dye, Director of Physical Therapy Sheboygan Memorial Hospital
What Everyone Should Know About Emphysema	Otto Radke, Director of Respitory Therapy, Sheboygan Memorial Hospital
Heart Problems	Jane Martin, R.N., Nursing Supervisor Coronary Care Unit, Sheboygan Memorial Hospital
Stroke	Vicki Wilke, R.N. St. Nicholas Hospital

PHYSICAL HEALTH INFO - Skin Care

Skin Care	Dr. Kevin Myers private practice dermatologist
Skin Care	Dr. Mark Knabel Sheboygan Clinic dermatologist

1983 Programs

PHYSICAL HEALTH INFO - Dental Care

Dental Care	Dr. Eugene Heller Private practice dentist
Dental Care	Dr. Dave Bolgert private practice dentist
Dental Care	Dr. James Nass private practice dentist
Dental Care	Dr. Paul Weber private practice dentist
Dental Care	Dr. Dennis Baus private practice dentist
Dental Care	Dr. Steven Lindstrom private practice dentist
Cost Awareness	Tom Hauert, representative Midwest Dental Clinic

PHYSICAL HEALTH INFO - Drug Use & Abuse

Generic Drugs	Mary Price local pharmacist
Generic Drugs	Chris Roenitz local pharmacist
Generic Drugs	Robert Holler local pharmacist
Wise Use of Medications	John Halverson, Pharmacy Director Sheboygan Memorial Hospital
Wise Use of Drugs (film)	Sheboygan County Public Health Nurses
Generic Drugs	Karen Soerens, Home Economist, Adult Services, Lakeshore Technical Institute

PHYSICAL HEALTH INFO - Other

Incontinence	Sheboygan County Public Health Nurses and City of Sheboygan Public Health Nurses
Arthritis	Mary Clabots, R.N., St. Nicholas Hospital
Diabetes	Handouts available at sites
Cancer	Handouts available at sites
Health Up-Date	Karen Soerens, Home Economist, Adult Services, Lakeshore Technical Institute
Being An Informed Patient	Karen Soerens

1983 Programs

ENVIRONMENTAL HEALTH INFO - Emergency Preparedness

Ways to Dress to Keep Warm	Laurine Gajewski-Evans Consumer Consultant, Wisc. Public Service
Dangers of Hypothermia	Laurine Gajewski-Evans Consumer Consultant, Wisc. Public Service
Home Safety & First Aid	Sheboygan County Public Health Nurses and City of Sheboygan Public Health Nurse
What to do In an Emergency	Betty Hardy, R.N., supervisor Emergency Room, Sheboygan Memorial Hospital
What to do In an Emergency	Terry Joosse, R.N., Emergency Room, St. Nicholas Hospital
Life Lines	Betty Hardy, R.N., Sheboygan Memorial Hospital
film and demonstrations of CPR and Heimlich maneuver	Sgt. John Webb, Sheboygan County Sheriff Dept.
Keeping the Furnace in Good Shape	Laurine Gajewski-Evans Consumer Consultat, Wisc. Public Service

ENVIRONMENTAL HEALTH INFO - Highway Safety

Rules of the Road	Paul Nyhof, Wisconsin Dept. of Transportation
Safety Belts & You (film)	Wisc. Department of Transportation
Being a Good Driver, A Good Pedestrian, A Good Passenger	Tom Tschanz, driver education instructor Sheboyan South High School

ENVIRONMENTAL HEALTH INFO - Home Services

Renting	Karen Soerens, Home Economist, Adult Services, Lakeshore Technical Institute
The Telephone Service	Karen Soerens, Home Economist, Adult Services, Lakeshore Technical Inst.
Owning Your Own Phone and Measured Service	Dick Lendl, Speakers Bureau, Wisconsin Telephone Co.
Owning Your Own Phone	Ann Weber, General Telephone
Cures for Crank Calls	Dick Lendl, Wisconsin Telephone Co.
Cures for Crank Calls	Becky Schirmer, General Telephone
Owning Your Own Phone and Measured Service	Jim Jacquart, Speakers Bureau, Wisconsin Telephone Co.

1983 Programs

MENTAL HEALTH INFO - Depression

Signs of Depression	Randy Wawiorka, Director Mental Health Association
Mind Over Matter, Positive Mental Health	Sheboygan County Public Health Nurses and City of Sheboygan Public Health Nurses

MENTAL HEALTH INFO - Social Security

Social Security	William White, Administrator Sheboygan Office, Social Security

MENTAL HEALTH INFO - Economic Concerns

Medical Care in Sheboygan Cnty.	Dr. Christopher Graf, President Sheboygan County Medical Society and private practice urologist
" " " "	Dr. James Kuplic Private practice internist
" " " "	Dr. John Hermann, urologist Sheboygan Clinic
" " " "	Dr. Curt Hancock, internist Sheboygan Clinic
Paying Doctor Bills	Office Manager, Sheboygan Clinic and one physician, whom ever was available on the day of the program
Estate Planning & Living Wills	Atty. Wm. TeWinkle private practice attorney
" " " "	Atty. Mel Blanke private practice attorney
" " " "	Atty. Jay Zierhut private practice attorney
Aspects of Funerals	Jim Krause, local funeral director
" "	Wayne Huehns, local funeral director
" "	Warren Wittkop, Jr., local funeral director
Informal Administration of Estates	June Martinson, Sheboygan County Register in Probate
Benefits	Jim McCabe, Assistant Director Office on Aging
Understanding Medical Costs	Lois Alpert, Outreach Worker Office on Aging
Medicare Spend down	Lois Alpert, Outreach Worker Office on Aging

1983 Programs

ENVIRONMENTAL HEALTH INFO - Crime

Crime Prevention	Officer Dewey Glancey, Sheboygan Falls Police Dept.
Crime Prevention	Officer Bernard Ross, Sheboygan Police Dept.
Consumer Protection/ Con Artistry	Special Investigator, Al Wagner, Sheboygan County District Attorney Office
Consumer Awareness	Karen Soerens, Home Economist, Adult Services, Lakeshore Technical Institute
Shopping by Mail	Karen Soerens, Home Economist, Adult Services, Lakeshore Technical Institute

MENTAL HEALTH INFO - Insurance

Supplementary Insurance	Robert Schrameyer, Credit Manager Sheboygan Memorial Hospital

MENTAL HEALTH INFO - Economic Concerns

Money Markets	Karen Soerens, Home Economist, Adult Services, Lakeshore Technical Inst.

HEALTH SERVICES - Blood Pressure Screenings

Done quarterly at each nutrition site	screenings done by Public Health Nurses or Volunteers

HEALTH SERVICES - Immunizations

Flu Shots administered each fall	County and City Public Health Nurses

DUKE UNIVERSITY MEDICAL CENTER

Department of Community and
Family Medicine
Administrative Offices

DEC 28 1983

December 20, 1983

The Honorable Ike Andrews
Chairman
Subcommittee on Human Resources
Committee on Education and Labor
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Andrews:

I have read with interest your bill, HR4472, relating to multipurpose senior centers education and training.

The purposes of the bill are highly commendable, but the proposed means for implementation are such that it will limit the usefulness of the bill.

Schools of Public Health are important resources for design and implementation of health education and training programs, but they are few in number, and some are extremely limited in their approach, dealing only with the training of professionals at a Masters or Doctoral level. Most of the nation's 120 medical schools have Departments of Preventive or Community Medicine, which are also actively involved in such activities. Many of these are more capable of designing and implementing such programs than their School of Public Health counterparts. In addition, Schools of Medicine are generally more actively involved in patient education, since they are actively involved in patient care.

Our Schools of Public Health are important resources, and we utilize them heavily for education and training of professionals in biostatistics, epidemiology, occupational health and safety, and related areas, but they are, as a group, poorly equipped by experience and background for direct education of patient groups. Restrictions of involvement by relevant departments of the nation's medical schools would be, in my opinion, a serious omission, which would compromise the laudable intentions of the bill.

With best personal regards,

Very truly yours,

E. Harvey Estes, Jr., M.D.
Professor and Chairman

EHE/sr

Box 2914 • Durham, North Carolina 27710 • Telephone (919) 684-5314

RALPH MCCALLISTER
507 MORGAN CREEK ROAD • CHAPEL HILL, NC 27514 • (919) 942-1971

Testimony from Ralph McCallister, member Orange County Commissioners Advisory Council on Health Care and Medical Service, at a hearing of the Hon. Ike Andrews, N.C. at the headquarters of the University of North Carolina in Chapel Hill December 20, 1983.

I call the attnetion of Congressman Andrews and his staff to the North Carolina Health Plan developed by the Coordinating Council in 1979. I was a member of the division dealing with Preventive Services. Particularily note the section on the medically underserved elderly and handicapped adults, beginning pg. 124, and section on the availability of primary care services, beginning pg. 282. These two sections which may already be familiar to you offer a studied analysis of the health care situation for older persons as it appeared in the state of North Carolina in 1979.

Approximately one half million persons in North Carolina do not have adequate health care. I t is either not accessible or it is not affordable. I point to these facts to note that education for older adults needing health care is not a substitute for that care, event hough it may be a needed supplement or integral part of adequate health care service.

North Carolina has been slow to develop comprehensive pre-paid health care for all of it's people. Achieving this will provide a base for a continuing health education program for all of the people including the older part of our population. I call your attention to the Contra Costa Health Plan spongored by the County government of Contra Costa County in California. It offers comprehensive prepaid health care which includes a large element of preventive care and health education to senior citizens, the indigent and County employees. I recommend that legislation for health education for older persons include some focus on the health care system so that older persons as consumers mayb eable to make decisions about the development of cooperative programs between local, state and federal governemrnt agencies, health care providers and consumers for comprehensive universal health care for all of our citizens including older persons.

My collleague Wil Morse, chairman of the Orange County Commissioners Advisory Council on Health Care and Medical Service will present the broader perspective of the Council interests.

University of Puerto Rico
Medical Sciences Campus
School of Public Health
G.P.O. BOX 5067
SAN JUAN, PUERTO RICO 00936

OFFICE OF THE DEAN

December 21, 1983

The Honorable Ike Andrews
Chairman
Subcommittee on Human Resources
Committee on Education and Labor
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Andrews:

I have read H.R. 4472 - A Bill to amend the Older Americans Act of 1965. As a public health professional I must express my satisfaction for the submission of such a bill. Aging is a biological process and no human being should be deprived of his right to be a member of a society in good standing because of his natural biological process of aging.

I think this is a very worthwhile initiative specially when the population over 65 about equals, in terms of census figures, the adolescent group. If the financial and economic aspects of helping an aging person through the last years of life are to be considered, it would be clear to each one of us that in terms of health services costs, they are by far the largest consumers.

We in the Medical Sciences Campus of the University of Puerto Rico designed a post graduate curriculum for health professionals which has been offered for the last two years and has been extremely successful. We expose our students to the following subjects: (1) Biology of aging, (2) Psychology of the elderly, (3) Sociology of the elderly, (4) Clinical Aspects of the process of aging, (5) Administration of Services for the elderly and a Practicum in anyone of the existing services in the island.

The professionals we are exposing to this curriculum, without any doubt, will be more than willing to get involved in activities directed to the well-being of the elderly or the aging and this is what appeals to me the most when I read H.R. 4472.

The Honorable Ike Andrews

December 21, 1983

Page 2

I urge you to take up the bill as soon as the House reconvenes in late January. If this gets up to be approved it should give you a lot of satisfaction and it will be extremely meaningful for the 11% of the population who are already there.

Sincerely yours,

Carlos N. Vicéns, M.D.
Dean
School of Public Health

CNV/cmd

EAST CAROLINA UNIVERSITY

GREENVILLE, NORTH CAROLINA 27834

OFFICE OF THE CHANCELLOR

December 21, 1983

Honorable Ike Andrews
Subcommittee on Human Resources
U.S. House of Representatives
Room 2178, Rayburn House Office Building
Washington, D.C. 20515

Dear Representative Andrews:

May I compliment and thank you for your interest in the elderly and for your foresight in introducing H.R. 4472, a bill which I believe has tremendous potential to assist our elderly citizens throughout the nation.

My assistant, Dr. Mary Ann Rose, attended the hearing which you and Representative Perkins conducted yesterday in Chapel Hill and informed me of the major points which were discussed. I would like to make three additional suggestions for your consideration.

The site for delivery of the educational programs concerns me. While use of existing senior centers is certainly a possibility, I suggest that the educational organization which is responsible for the project also be responsible for selection of the proper delivery mechanism. For example, here in eastern North Carolina there are no such senior centers. However, there are other ways in which East Carolina University reaches the elderly, such as our Division of Continuing Education which extends into even the smallest rural communities.

I also echo the concern of others that limiting the selected educational institutions to those with Schools of Public Health is unnecessarily restrictive. East Carolina University, for example, has a Department of Health and Physical Education in the College of Arts and Sciences, several programs in the School of Allied Health and a Division of Gerontology in the School of Medicine. I can assure you that we have capability to carry out the proposed program for the citizens of eastern North Carolina. However, limiting the participants to Schools of Public Health would deny us that opportunity.

A final suggestion which I might make is that funding be available to selected educational umbrella institutions such as the American Association of State Colleges and Universities. Such an association could coordinate development of alternative models of both curriculum and delivery methods which could then be demonstrated and compared by a common evaluation scheme.

Again, my thanks for your concern.

With best wishes,

John M. Howell
Chancellor

JMH/gcg

JAN 5 - 1984

Suzanne Lassiter
Route 2, Box 446
Chapel Hill, North Carolina 27514
December 21, 1983

Ike Andrews
United States House of Representatives
Washington, D.C.

Dear Mr. Andrews;

I have been reading about your health education bill for older adults in the paper and am very excited about the possibilities it could open up for this underserved population. I was pleased to see that you plan to use college students as the primary teachers. I am a senior nursing student at the University of North Carolina at Chapel Hill and would have enjoyed participating in a program such as this.

Enclosed is a copy of a program proposal which I developed this fall. As you can see, I had a similar idea of using college students to cut costs and provide training. I also proposed using a professional nurse already employed by a local health department as a part-time coordinator

I would be interested in your reaction to my proposal and will be watching with interest for future discussion of your bill. Thank-you for your time and good luck!

Sincerely,

Suzanne Lassiter

The Get Up Program

exercise and movement education

for the older adult,

a proposal.

SUMMARY:

Programs of exercise in Chapel Hill are increasing rapidly. Unfortunately their scope does not cover the low income elderly who offer little profit motive for new businesses. The planner of this program is a student nurse who worked with a group of elderly at a local nutrition site. The clients expressed an interest in exercise and were later led through a short stretching and movement class. Response by the group was enthusiastic. This proposal is to provide an ongoing program of total fitness through the use of a daily teaching segment followed by a low stress exercise program. Projected costs will be an initial one thousand and fifty dollars to renovate a room already being used by the group. The salary of the coordinating nurse will be paid for by the Orange County Health Department. The nurse will orient a group of recreation therapy students to be the exercise leaders.

INTRODUCTION:

This program is being proposed by a senior nursing student at the University of North Carolina at Chapel Hill. She worked with an elderly group of clients who attend the nutrition site at the Multi-purpose Center in Chapel Hill over a several month period. These people are low income, black men and women, most

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of them over sixty. Several are younger than sixty but do not stand out as being more healthy than the others, apparently prematurely ageing due to chronic illness or poor nutrition. Most of them suffer from at least one chronic disease or condition such as hypertension, arthritis, obesity, a[illegible]nt disease. Many of them walk slowly and move very little [illegible] at the nutrition site. Their posture is stooped and stiff. One of the presentations done for the clients was concerned with exercise and movement. Clients were led through a stretching and low stress movement class. They were more capable and enthusiastic than expected.

PROBLEM STATEMENT:

There is a strong trend towards physical fitness in the Chapel Hill area. There has been a proliferation of health spas, aerobic classes, and running programs. Unfortunately almost all of these programs have focused on those who are young, healthy, and middle or upper class. There have been almost no programs opened up for the ageing, especially those in the low income bracket. This may be due to the lack of a profit motive in developing such a program. Benefits suggested from physical fitness in the aged include resistance to disease, improved heart rate, blood pressure, and myocardial circulation, a more favorable body fat and muscle composition, and increased vigor and pleasure in life.[1,2] A study by Borken and Norris has shown evidence that physically active men are biologically younger

than inactive men.[3] Conclusions may be drawn from this that the physically active may live longer or at least increase their years of leading active and productive lives. Keeping in mind the high costs of health care, especially that associated with the chronicly ill older adult, it stands to reason that keeping the elderly as physically fit, free from diseases, and active as possible will save money for the public in the long run.

PROGRAM GOAL:

To improve the physical fitness of a subpopulation of the low-income elderly in Chapel Hill and thereby decrease restrictions on lifestyle and mobility from chronic disease and premature ageing.

PROGRAM OBJECTIVES:

After one year's participation,

1. Clients will have significantly improved flexibility in the hips and hamstring muscles as measured by the flexibility testing bench.
2. Clients will have significantly improved body images as measured by comparison of questionaires answered before and after treatment.
3. A random sample of twenty clients will have significantly increased their aerobic capacity as measured by an increased maximum oxygen intake per unit of body weight. This

measurement was used by Aniansson, et al. with a group of seventy year old men before and after an exercise treatment.[4]

4. The same random sample of clients will demonstrate significantly increased range of motion.

PROGRAM METHODS:

The Get Up Program will be staffed by a professional nurse already employed by the Orange County Health Department and a rotating group of recreational therapist students from the University of North Carolina at Chapel Hill. The nurse will work on this program part time and will have other duties assigned to her by the health department for her full position. She will be in charge of coordinating the program, carrying out teaching segments , and orienting the recreational therapist students to their role within the program.

The first step will be a modification of the room to be used. This is the room presently used for the nutrition site in the Multi-Purpose Center in Chapel Hill, North Carolina. It is a large room, approximately twenty feet by fifty feet. The floor must be padded and carpeted to help prevent stress injuries during exercises. The room will also need to be equipped with a stereo sound system.

All clients attending the nutrition site will be eligible for participation. They will be required to sign a form releasing the health department of responsibility for any injuries during the classes. They will also sign a register

sheet daily for each class. If overattendance and crowding becomes a problem, only the first forty clients to sign up for the day will be accepted.

The program will last from nine-thirty to ten-thirty in the morning and will take place Monday through Friday. It will begin with a twenty-five minute teaching segment given by the nurse. Topics to be covered include foods for energy (low fat, high carbohydrate), energizing body mechanics in housework and daily tasks, using music to make doing chores fun, and positive body imaging which will involve leading participants through body awareness exercises, non-competitive and touch promoting "New Games", and group discussions of ways for clients to learn to accept and be proud of their bodies as they are, not as society says they should be.

Following the teaching segment, will be a thirty-five minute exercise program led by a rotating shift of recreational therapy students. They will lead the clients through a three phase workout as recommended by Camaione and Sinatra.[5] There will be ten minutes of "warm up", which involves stretching out muscles and preparing the body for activity, fifteen minutes of aerobic dance with a music accompaniment, and ten minutes of "cool down" with easy stretching to allow the body to return to normal.

Leaders will emphasize enjoyment of exercises. Everyone will be encouraged to go at their own speed, resting their bodies when appropriate. Clients will be encouraged to attend

at least three sessions per week since this is the minimal frequency found to be effective in cardiovascular training.[6]

A group of five recreation therapy students will be assigned to the program for each semester as part of their practicum experience with the elderly. The nurse will orient the students to the program but allow them freedom to develop their own routines either as a group or separately. Co-leading by clients will be encouraged once they have memorized steps or feel comfortable with a new routine. Continuity during breaks between school semesters will be provided by client leaders once the program has matured (benefits of exercise can be lost in only eight weeks of inactivity).[7] The nurse will act as a substitute leader until that time.

EVALUATION:

All clients will be measured for flexibility utilizing a flexibility testing bench similar to that developed by Tichy and Tichy.[8] This is a simple device which can be visualized by imagining a person standing on a straight backed chair. The person bends from the waist, allowing their arms to slide along the back of the chair. The farthest point that the fingers meet without undue strain is marked and determines that person's flexibility. Flexibility measurements will be taken by the nurse for all new participants. These measurements will be repeated at the end of one year to determine if a significant change has occurred.

A questionaire will be devised and administered by the nurse to elicit information about body awareness. self esteem, and body image. A Likert scale will be used to measure agreement with such statements as "I feel good about my body", "I sometimes forget my legs are there",and "I don't like to move my body." Answers to these questions will be compared to a post-treatment questionaire at the end of one year.

Once forty clients have signed up for the program, twenty will be selected by random drawing to be measured more specificly by the exercise physiology department at the University of North Carolina at Chapel Hill. Their maximum oxygen uptake per unit of body weight will be measured to determine their aerobic capacity. Range of motion will also be evaluated in all joints of the body. If forty clients have not signed up for the program within two weeks of its start the first twenty clients or however many have signed up will be measured. These measurements will be repeated at the end of one year and significant differences noted.

At the end of every school semester, clients and students will be asked to give their subjective evaluations of the program. The nurse will lead a discussion group in which clients will be asked open-ended questions such as "How has the program effected your life" Students will be asked to write down their rating of the program's effectiveness in improving physical fitness of the clients, what other benefits they see arising from the program, how they might have felt blocked in

implementing their plans, and what they would like to suggest as changes for the future.

At the end of the first year results of tests to determine program effectiveness and feedback from clients and students will be analyzed by a team made up of the coordinating nurse, two volunter representatives from the elderly group, a representative from the State Department of Human Resources, Division of Health Services in Raleigh, and a representative from the Town Council of Chapel Hill. Participation by members of the elderly group gives them the chance to express their opinions and provides a good measure of the program's success. Representatives from the state and local level of government are invited in order to receive input for improvements and to acquire public backing of this program and ones similar to it in the future. The coordinating nurse will analyze the data and present results to the team. The team will then draw conclusions and devise a report of their findings to be submitted to the Division of Health Services in Raleigh, the Chapel Hill town council, the Orange County Health Department, local papers, and any prospective sources of funding. This report will state whether there were significant differences between pre-treatment and post-treatment measures and will make recommendations for future planning. The report will be completed within six weeks past the first year of program operation.

FUTURE FUNDING:

The future cost of this program are minimal. The only staff position, the coordinating nurse, will be continue to be paid by the Orange County Health Department. Recreation therapy student interns will not be paid for their services. The room to be used has already been allotted to the group for which it will be used and requires little additional maintenance. Carpet may have to be replaced or repaired. New tapes will be bought periodically for the sound systen, but will not be a major expense. Transportation for clients to the multi-purpose center and home again is presently provided free of charge. The time for picking up clients in the morning must be adjusted so that they will arrive by nine-thirty.

BUDGET:

Personnel expenses, paid for by the Orange County Health Department, will be ten thousand dollars per year for a half time position of the nurse coordinator. This position must be filled by a professional nurse with a strong background in teaching and an ability to analyze and interpret research data. She must also have strong organizational skills and be well versed in body awareness and physical fitness techniques for the elderly.

Other non-personnel costs include five hundred dollars for carpet and padding of the exercise room, five hundred dollars for a stereo sound system, and fifty dollars for the purchase of initial tapes and records to be utilized in the program.

ENDNOTES

1 Strauzenberg, "Sport in Old Age: Advantages and Risks," Journal of Sports Medicine and Physical Fitness, Vol. 21, No. 4, December 1981, p. 309-321.

2 Camaione and Sinatra, "Beneficial Effects of Exercise and Current Concepts in Adult Fitness, Connecticut Medicine, Vol. 45, No. 10, October 1981, p. 620-625.

3 Borkan and Norris, "Biological Age in Adulthood: Comparison of Active and Inactive United States Males," Human Biology, Vol. 52, No. 4, December 1980, p. 787-802.

4 Aniansson, et al., "Physical Training in Old Men," Age and Ageing, Vol. 9, No. 3, August 1980, p. 186-187.

5 Camaione and Sinatra.

6 Scheuer and Tipton, "Cardiovascular Adaptations in Physical Training, Annual Review of Physiology, Vol. 39, 1977, p. 221-251.

7 Strauzenberg.

8 Tichy and Tichy, "Physical Fitness in the Elderly," Medical Instrumentation, Vol. 16, No. 1, January 1982, p. 20-21.

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December 21, 1983

The Honorable Ike Andrews, Representative
U.S. House of Representatives
2201 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Andrews:

I am very encouraged by HR 4472 you have propsed as an amendment to the Older American's Act.

I worked for four years with the Mid-East Commission Area Agency on Aging which served Beaufort, Bertie, Hertford, Martin and Pitt Counties. While in that position, I developed one of North Carolina's first comprehensive health education programs for the elderly called "Health and the Older Adult". I also served on the steering committee for the statewide health education program developed by the Division of Aging "LIFE". Currently, I am the coordinator for Community Health Services and in this capacity continue my commitment to quality health education for the elderly in the twenty-nine counties which the ECU School of Medicine serves.

I wholehearted support your efforts. In my opinion the bill is workable and the objectives can be accomplished with little public money if much coordination among local agencies and institutions is mandated. My suggestion is that the cirriculum be developed on a regional (perhaps AAA) level. Many health problems and most health solutions are area-specific. I think that this is very evident when comparing Greenville to New York City; but is forgotton when comparing Raleigh to Windsor. When implementing this amendment I hope that this suggestion will be considered.

Your commitment to the elderly of this state and the nation is greatly appreciated. If I, or the ECU School of Medicine can be of any assistance with this endeavor, please do not hesitate to contact me.

With best wishes for a happy holiday season, I am

Sincerely,

Karen Vail-Smith

Karen Vail-Smith, Coordinator
Community Health Services

Center for Health Services Research and Development
School of Medicine, East Carolina University, Greenville, North Carolina 27834
(919) 757-2785

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL

The School of Medicine
Department of Family Medicine
919-966-5742

22 December 1983

The University of North Carolina at Chapel Hill
Trailer 15, 200 H
Chapel Hill, N.C. 27514

Michel Ibrahim, MD
School of Public Health
168 Rosenau Hall 201H
UNC Campus

Dear Michel:

I have recently read in the newspaper and heard on the radio about the proposal for health education activities for individuals over 65. I wanted to bring to your attention an activity designed through the Mountain Area Health Education Center which might be useful in this regard. I have become aware of a series of videotapes and programmed learning resources through MAHEC entitled "Health Education for the Elderly". These tapes and other materials are available through the MAHEC library and through Richard Walton, MD, MAHEC Family Medicine Residency Program, 430 Biltmore Avenue, Asheville, NC 28801.

I hope this bill progresses well, as it is sorely needed and in an area of great interest for all of us caring for older patients.

Best wishes,

John J. Frey

JJF/mg

The Honorable Ike Andrews:

Dear Ike:

This should be of interest.

Best wishes for the Holidays

Michel
12-29-83

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL

Office of the Dean
The School of Medicine

The University of North Carolina at Chapel Hill
MacNider Building 202 H
Chapel Hill, N.C. 27514

DEC 27 1983

December 22, 1983

The Honorable Ike F. Andrews
United States Congress
2210 Rayburn House Office Building
Washington, DC 20515

Dear Ike:

I want to thank you again for your initiative in conceiving of the approaches to health care for the elderly which are contained in H.R.4472. It was a great pleasure to participate in the hearings which you held and I hope very much that my contributions were useful in the further development of the bill.

I especially wanted to add a comment concerning a point which Ernest Messer made after I spoke. Ernest emphasized the importance of assuring that the educational programs in the senior centers work closely with the divisions of aging in the state health departments. He pointed out that this is a way of assuring appropriate involvement of all of the elderly.

I want to support very strongly Mr. Messer's suggestion and to suggest that a way of implementing the suggestion would be to make it clear that it is the intent of Congress that the granting agency has as an announced condition of awarding such grants the requirement that evidence of coordination with the Division of Aging be presented as a part of the grant. I believe that Mr. Messer was quite correct in his observations and I am confident that the programs in North Carolina would work immeasurably better through close interaction with his office.

I thank you again for inviting me to testify. I will be glad to help with the further development of the legislation in any way that I can.

With best regards.

Sincerely,

Stuart

Stuart Bondurant, M.D.

SB:jps

cc: Mr. Ernest Messer

JAN 3 1984

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL

School of Social Work

The University of North Carolina at Chapel Hill
223 E. Franklin St. 150 A
Chapel Hill, N.C. 27514
Tel. (919) 962-1225

28 December 1983

Mr. Gordon A. Raley
Staff Director
Committee on Education and Labor
U. S. House of Representatives
Room 2178
Rayburn House Office Building
Washington, DC 20515

Dear Gordon:

I was glad to have the opportunity to clear the air with respect to the recent hearings in Chapel Hill on the H. R. 4472. I was also pleased to support the idea behind this bill, since, as I mentioned in my talk with President Friday, we have had some experience with using students in Senior Centers, and we know that students can be helpful in such situations. The questions which I raised should not be seen as opposition to what would be an important improvement in the Older Americans Act.

I am enclosing a copy of the material I shared with President Friday for your information. I hope we will have further opportunity to participate in refining H. R. 4472.

Best wishes for the New Year.

Sincerely,

Andy

Andrew W. Dobelstein, Ph.D.
Professor

AWD:v

Enclosure

The University of North Carolina at Chapel Hill

School of Social Work

Comments on H.R. 4472

At the urging of Dr. Ellen Winston, the School of Social Work began a special program of study in 1978, called Service to Older Adults, available on an elective basis to social work students and others in the University. The program received special Title XX funding in 1979 and in 1980. When this funding terminated, the School continued the program support. In the past five years, twenty social work students have graduated and presently serve North Carolinians in various positions, from the State Aging Office to Senior Centers. These comments are based on experiences derived from educating these students.

Senior Centers are appropriate locations for professional training, but service to older people is most effective when provided by multiple disciplines. No single discipline is sufficient to satisfy the divergent physical and mental well being requirements of older adults. Our students served older people during their education through a field learning center based in a network of seven senior centers administered by the Coordinating Council for Senior Centers in Durham. We were able to mix our social work students into the overall work of this center through collaboration with ministerial students, recreation therapy students, nutrition students and others who also used the center as their educational base. Thus the education of the students was enhanced, and the service they were able to provide to older people improved considerably.

It might be important to note that there are eleven social work schools in North Carolina, scattered around the state. The University also provides other

people, but by restricting the professional groups, the proposed Title VII ignores the considerable potential of using these other professional students to achieve the amendement's objective.

Education, along with community service, is a primary mission of this University. Offering students the opportunity to serve older people without a strong educational design robs both older people and students. We found it necessary to construct a curriculum within the Senior Center, in addition to the special curriculum in the classroom, in order to provide support for the students enthusiastic help. This curriculum was developed by a multi-disciplinary group and was available to all those who worked at the Senior Center. (Report attached.)

While it is desirable to have a title of the Older Americans Act available to provide resources and leadership to enable professional students to serve our older citizens, Title IV of the Older Americans Act presently authorizes education and training. Unfortunately, Title IV has been interpreted by AOA so as to prohibit the use of funds for career preparation. Thus, it might make sense to amend Title IV for greater flexibility, while pursuing efforts to include this new title into the Act.

Andrew W. Dobelstein, Ph.D.
Professor, School of Social Work
December 14, 1983

37-620 O—84——20

THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL
SCHOOL OF SOCIAL WORK

Specialization in Services to Older Adults

Field Learning Center

First Annual Report with Recommendations

May 1, 1982

Andrew N. Dobelstein, Ph. D.
Professor and Specialization Chairman

The Field Learning Center was begun in the Fall, 1981 as a means to maximize student learning through an integrated program which provided opportunity for practice social work skills and learning about older people and the kinds of help which they needed in order to live satisfying lives. The Center is located at one of the Senior Center sites administered by the Durham Coordinating Council for Senior Citizens, a non-profit multi-service agency for older adults. This agency is directed by a citizen Board of Directors and administered by Ms. Ann Johnson, a social worker. Ms. Johnson is nationally known for her work with older people and presently serves on the board of the National Council on the Aging.

Administrative Arrangements

An agreement between the agency and the school exists which acknowledges the school's authority over the learning content at the center and the agency's authority over the program content. Within this framework, learning relevant assignments are developed for the students by the educational coordinator. By similar agreement, the educational coordinator worked two positions: part of the time she provided services for the agency; the other part of her time she undertook those tasks associated with field education for five students. The educational coordinator was given faculty status with the school. The agency paid half the salary of the educational coordinator. The school paid the other half. The educational coordinator, Ms. Margie Freeman, is a social worker with twelve years of practice experience, including one year of experience with the agency prior to the development of the Learning Center. No arrangements for costs of assistance rendered by the executive director and other staff members.

Programmatic Features

The program of the Center operated from three distinctive directions: practice opportunity for students to develop social work skills under social work supervision, structured learning opportunities for students about older people and their needs, including structured learning regarding available resources to help older people and how to use them (the aging network), and opportunities for continuing education on timely topics.

(1) Practicing social work skills

The school's specialization on aging is committed to an educational model which emphasizes the development of social work practice skills which enable professionals to work directly with and indirectly in behalf of older people. Thus the program was structured to provide students with knowledge and practice opportunities in face-to-face counseling-type work with older people as well as opportunity for program planning, development and administration, program evaluation, staff development and social policy building. Because each student wanted to develop a unique mix of practice skills, it was possible through the center concept to design a set of practice opportunities for each student which met that student's professional interest.

Assignments for each student were developed by combining a set of anchor and satellite assignments. Each student received an anchor assignment at the Center (in the agency), and depending on individual needs, satellite assignment(s) were developed in cooperating agencies. For example, one student wanted more face-to face counseling opportunities. She was given a satellite assignment in a counseling agency where she managed a caseload of older adults. Another student wanted policy development opportunities. She was provided with a satellite assignment with the State Aging Office.

The purpose for the anchor assignment was to insure a common core of practice experience around which the generalized academic course work could be integrated

in regular supervisory sessions. Additionally, each student was assigned to work with a group of older people at the Center (in the agency) as a means to supplement core learning content and to provide opportunity to develop group work skills.

(2) Structured learning opportunities about older people and their needs

Students were provided with two types of supervision. Case supervision for each of the satellite assignments was provided by a qualified person at the satellite assignment site. Case supervision by the educational coordinator was used to integrate work with the anchor assignment and those elements of supervision which fostered integration of knowledge and practice, generally, in order to achieve greater practice competence.

This second supervisory task, often the very core of social work field education, was facilitated by a deliberate introduction of materials into the student's learning matrix by the educational coordinator. No overall plan for timing the introduction of this material was made, but as the year progressed, it became apparent that there were appropriate points in the student's learning process which content was most useful in this more structured form. For example, before the students became deeply engaged in their specific assignments, a comprehensive introduction to resources of the aging network was provided to the students. Later, as students began work with assignments, materials on the aging process were provided in the form of video-tapes of older people. At the point when students were making plans for work with clients and groups, students were introduced to the use of assessment tools. These structured learning opportunities were proposed in the overall educational design, and they became central themes in the learning process.

Generally, the first and third Fridays of each month were used as that time which focused on the integration of theory and practice. In the morning, each student worked with his or her group. Each student also met individually with the educational coordinator to discuss sepcific learning issues with respect to

practice. In the afternoon, a structured learning experience would be provided as indicated. In these afternoon sessions, students had expanded opportunities to talk with each other and the educational coordinator about their work of that week and to discuss the relevance of the structured learning experience with individual cases in both anchor and satellite assignments. These sessions were extremely productive and of great benefit for the students.

(3) Opportunities for continuing education on timely topics

Students were encouraged to engage in as many workshops, meetings, seminars, and special programs available to professional workers in the community as they possibly could manage. For example, students attended two workshops sponsored by Duke University OARS clinic, participated in a workshop with Maggie Kuhn at Appalachian State University, and attended the Black Experience Workshop at UNC-Chapel Hill. As a means to encourage interaction between students and practicing professionals, and as a means to provide service to the community, the Center developed and provided a year-long seminar, "Long Term Care: What Is It? Who Does It?" for practitioners in the Durham, Raleigh, Chapel Hill area. This seminar met the second Friday afternoon of each month. Eight sessions of the seminar were offered: each session was composed of a formal presentation by a well known person in the field, followed by small discussion groups. Students participated actively in these discussion groups. The seminar was well attended and well received. Attendance averaged 30 persons. Continuing education credit from the University of North Carolina was given for those in the general practice community who participated.

Ronald H. Levine, M.D., M.P.H.
STATE HEALTH DIRECTOR

DIVISION OF HEALTH SERVICES
EASTERN REGIONAL OFFICE
404 St. Andrews Street
Greenville, N.C. 27834
(919) 756-1343

December 28, 1983

The Honorable Ike Andrews
United States Congress
Washington, DC

Attention: House Human Resources Sub-Committee

Dear Congressman Andrews:

I have followed with interest your national hearings to seek input about the health education needs of the elderly. It is very encouraging to learn that a congressional leader is interested in preventive measures to promote healthier older adults.

I was not able to attend the recent hearing in North Carolina but would like to submit for your information a paper I wrote last year that outlines some of the priority areas for health education that were identified by home health providers in the Eastern part of this state.

At the time the providers were surveyed a new state initiative was being promoted called H.B. 405. As the paper outlines, this initiative was supposed to help older people function in their homes. It would appear, as I am sure the hearing participants illuminated, that health education about preventive health measures would be essential for increased at-home functioning of the elderly. Unfortunately, the reimbursement system incorporated in the various Medicaid and Medicare rules prohibits preventive services. This is evidenced by the problems that home health nurses have in providing needed services that could keep older people out of institutions as well as the lack of nutritionists and health educators in home health programs. H.B 405 seems to be stimied from our perspective in the Eastern part of North Carolina and I am really not surprised considering the parsimonious, short-sighted philosophy of the Federal regulators.

I am glad to learn about a new avenue for providing needed education to this segment of the population and wish you the best success in initiating this important program.

Sincerely,

Gary Taylor

Gary Taylor, MPH
Health Education Consultant

Enclosure

HEALTH EDUCATION NEEDS IN THE HOMEBOUND POPULATION

Gary A. Taylor
North Carolina Division of Health Services
404 St. Andrews St.
Greenville, North Carolina 27834

February 15, 1983

Running head: Health Education for Homebound

Abstract

Home health nurses and aides in eleven home health agencies in Northeastern North Carolina identified chronic illness management, meeting nutritional needs, and caring for a bedridden family member as the priority areas for health education of the population targeted by a new legislative program to help the disabled or aged remain in their homes. The majority of respondents (97%) indicated they encounter a significant number of people who could benefit from expanded preventive health services including health education and supportive care.

Health Education Needs in the Homebound Population

The increasing aging population in the United States is predicted to place great demands on the medical and long-term care system. By one estimate, the nation's health care bill may approach one trillion dollars by the year 2000.[1] This increase will be partially attributed to the aging of our society. The greatest increases in population growth during the next 25 years will be in the 45-65 and 65+ age groups. Because this group is subject to costly chronic illness and debilitation that denies self-sufficiency, measures to enhance the ability of older people to avoid institutionalization are essential if alternatives to this predicted medical-demographic crunch are to be found.

Increasing restrictions in medical insurance, private and governmental, have made the provision of home health services available only to the most severely ill. Health providers who give care in the home are repeatedly frustrated by the denial of insurance approval for services to "borderline" patients. These are people who need supportive help to keep healthy or maintain their independence but cannot be provided reimbursable services that are preventive.

In the 1981 session of the North Carolina General Assembly, a bill was passed entitled H.B. 405: DHR to Encourage Home Care of the Aged. This bill seeks to provide remedies for the problems of an increasingly older and institution-bound population by initiating on an experimental

basis, a screening mechanism to assess personal needs for supportive or medical service. Administered at the local level, this screening/assessment program would find people who otherwise would be destined for nursing home placement and coordinate for them a variety of supportive services in the home.

The General Assembly appropriated a very modest sum to test this new system in three counties. The major funding to pay for the supportive service through H.B. 405 was to be obtained through a Medicaid waiver—a specially granted exception to the reimbursement rules to be sought from the Federal authorities. This waiver was recently obtained; however, the local social service agency must continually document for each person served that the cost of the home service is less than the cost of institutional care.

The services that may be offered under the Medicaid waiver include:

1. case management and screening
2. homemaker-home health aide
3. chore worker
4. adult day care
5. habilitation
6. respite care
7. meals
8. durable medical equipment
9. home mobility aides

The author, a health educator practicing in a rural region of North Carolina, welcomed this step by the legislature toward preventive services

for the elderly. In order to identify the educational needs of the group targeted for expanded home based services, a survey was conducted with 38 home health providers including 33 nurses, aides, or supervisors and 5 allied health professionals in Northeastern North Carolina. Respondents indicated that they encounter a substantial number (20 or more per year) of patients who could benefit from preventive education.

One of the greatest areas of need for homebound health education was in nutrition; a service that is often preventive in focus and not reimbursable under present insurance restrictions.

Table 1

Also checked as a priority for homebound education was instruction in caring for a bedridden family member and in managing a chronic illness. Teaching the homebound to deal with these problems is a process that lends itself not only to instruction through medical management but also to organized teaching programs using appropriate audio-visual and curriculum materials. The psychological needs of the elderly require a supportive learning environment that allows for self-paced learning and takes into account the need for repetition, practice, feedback, positive reinforcement, and compensation for sensory losses. When asked about the educational resources needed to address the priorities identified, the respondents listed their own continuing education and training in gerontology as well as appropriate teaching aides.

Discussion

There is much evidence for the economic and social benefits of helping disabled or aged people to stay at home, as well as for the need for effective, organized home teaching.

Often plans for health promotion are focused on the school age or working population in hopes of initiating lifelong practices. It should not be forgotten that the elderly can also benefit from health promotion. A person at 60 confronts many choices that may determine his well-being for another 10 to 20 years. Retirement is a time of major life changes and is a point of learning readiness. Facing social, physical and psychological changes, the older learner finds health choices are an important part of his decision making.

Healthy people, the United States Surgeon General's report about health promotion and disease prevention (1979) lists the major health problems to which the older person must adapt:

1. 44% of those persons 65+ have arthritis.
2. 22% of persons 65+ have reduced vision.
3. 29% of those 65+ have heart conditions.
4. 35% of those 65+ have hypertension.
5. Respiratory conditions such as chronic bronchitis are a frequent cause of limited physical activity.
6. Sensory losses may cause the aged person to be labeled "senile."
7. Misuse of drugs is a major problem for the aged.
8. Social isolation contributes to mental deterioration.

9. Many chronic diseases such as diabetes, cancer, hypertension, and glaucoma are age related.

10. Influenza is a major cause of death in the aged population.[2]

Obtaining and financing adequate medical services for our aging population is a problem approaching a crisis. The costs of chronic illness are increasing at such an accelerated rate that major changes may soon be made in the financing of medical care. The Medicare system which now pays for 75% of hospital costs for the aged is expected to soon go bankrupt--by 1988 if the economy continues to lag.[3] Rising medical costs are the chief reason why Medicare is in trouble.

Faced with these problems, the Reagan administration is considering minimum income standards for Medicare eligibility, thus changing the philosophical foundation of Medicare from earned health security to health welfare for only the most needy.[4] The proposed means test would shift responsibility for insuring the health of many of the elderly to the state-federal Medicaid Program.[5] The states are not likely to welcome additional Medicaid expenditures.

Nursing home care takes about 32% of the Medicaid dollar. Hospital services take 36%.[6] Preventive services take a very small cut of the health care expenditures for the elderly, yet it is apparent that prevention and health conservation are important elements of any equitable solution to the problem of providing health services to the aged.

Health and support services that maintain the older person in a home setting are important preventive measures for physical and psychological

well-being. Home for the older person is everything. The psychological support from familiar objects, a secure environment, and independent living are directly tied to the quantity and quality of life. Sensory losses and diminished physical capacity may lead a person without adequate support to a premature nursing home prescription. Smith (1978) relates:

> If the failing older person could see himself and his needs and could verbalize them, he would mention the isolation which continues to remove him from relationships with others until he is like a small, oarless boat drifting far from a familiar shore (p. 6).[7]

Conclusion

These psychological needs, coupled with the predictable onset of physical impairments, indicate why health education of the homebound is important. Those people marginally impaired by health concerns or those isolated by age or family losses have a lot of new learning to undertake about managing their health or lifestyle. The mastery of new skills and information related to aging or chronic illness can be instrumental in determining the duration and quality of life in the later years.

Those who provide education and support for the elderly have an opportunity in home health services to develop new educational programs for home teaching in self-directed and one-to-one formats. The need for training and skill development in gerontology and adult education should be addressed by training programs in the university and health care settings. Greater educational resources applied in the home environment could be beneficial to many people in need who otherwise may become nursing home candidates.

Table 1

Health Education Most Beneficial for Continued Functioning of Target Population

Educational Need	Number of responses*	% of total
Managing chronic illness	25	16
Making consumer health choices	8	5
Control of stress	15	9
Use of adaptive aides	10	6
Managing a home	9	6
Meeting nutritional needs	26	16
Obtaining adequate exercise	3	2
Providing for bedridden family member	26	16
Maintain adequate social support	6	4
Practice oral hygiene	3	2
Personal cleanliness	11	7
Mobility or stretching exercise	6	4
Keep heating system safe	2	1
Organize living arrangements for security	5	3
Others[a]	4	3

[a]Proper administration of medicines; education in case management for homemakers and chore workers; managing isolation; obtaining a medical home; and getting help after 5 p.m.

*38 home health providers were surveyed in October-November of 1982. 31 (82%) responded. Participants were selected on the basis of their extensive experience in home health services.

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Route 2, Box 232
Denton, N.C. 27239
DEC 30 1983

Mr. Ike Andrews
Congress of the U.S.
House of Representatives
Washington, D.C. 20515

Dear Mr. Andrews

Unless I don't understand the Older Americans Act, I can't see that it would benefit many elderly people. Most of the elderly people I know would not have transportation or their health would not permit them to attend classes. Also many have physical disabilities that make it difficult to travel. Especially, the people in rural areas would not be able to participate in such a program. Also, most of the elderly already have health problems that education can't help.

I hope that you will re-evaluate this program to see that it is really worthwhile, as we don't need anything else to spend money for that isn't necessary.

Sincerely
Mrs Kermit Hancock

P.S. My husband and friends share my opinion.

37-680 O—84——21

Northwest Piedmont
Council of Governments

Joe C. Matthews,
Executive Director

280 S. Liberty Street, Winston-Salem, N.C. 27101 (919) 722-9346

JAN 9 1984

January 5, 1984

Honorable Ike Andrews
U. S. Representative
2201 Rayburn HOB
Washington, D. C. 20515

Dear Congressman Andrews:

As the Area Agency on Aging for Region I, a five-county area in North Carolina, we wholeheartedly support your proposed amendment to the Older Americans Act which would establish Title VII.

I commend you for your foresight in introducing HB4472. The addition of health education and training to the Older Americans Act would strengthen the positive impact it is already having with older Americans. Current health programs are designed to assist after a person becomes ill. With the rising costs of medical care, we can no longer afford to take the chance of becoming ill. We must learn how to regain our health and how to remain healthy.

I would like to suggest flexibility in designating the sites where the training programs would be held. My region has a population of 58,693 older adults, yet there are only two multipurpose senior centers. However, in addition, we have nineteen (19) nutrition centers which serve noon-time meals under Title III-C of the Older Americans Act. These centers are open three to four hours each day and could also be utilized as sites for the health education program.

I also would like to suggest that in any program which receives funds, the Area Agencies on Aging be involved. In order for Area Agencies to effectively carry out their stated mission, we also need to be involved with the planning and administration of the proposed health education programs.

Again, I reiterate my support for HB4472. A health education and training program would greatly enhance the lives of older adults.

If I can be of any assistance to you, or if you wish for me to clarify my suggestions, please call.

Sincerely,

Rodessa Mitchell

Rodessa Mitchell
Administrator
Area Agency on Aging

RM:KK:sn

JAN 19 1984

Jan. 5, 1983.

COMMITTEE ON EDUCATION AND LABOR,
U.S. House of Representatives,
Room 2178, Rayburn Office Bldg.
Washington. DC. 20515.

SubcommitteeOn Human Resources:

Field Hearing on H.R. 4472, to amend the Older Americans Act of 1965, Chapel Hill, N. C.

STATEMENT OF WILBUR L. MORSE

My name is Wilbur L. Morse. I attended the field hearing on H.R. 4472 held in Chapel Hill, N.C. on Dec. 20, 1983. Permission was granted by the chairman for me to file a written statement as part of the record of that hearing.

Background statement:

I serve as chairman of the Orange County Health & Medical Care Advisory Council. That organization was chartered by the Board of Commissioners of Orange County and charged with the task of studying health matters in Orange County and ultimately to make recommendations regarding a comprehensive health program accessible to all citizens of the County. The short term goal of the Council is to promote the coordination of the delivery of all in-home health services in the county. This goal of coordination of long term care is of prime importance to senior citizens. Any such program must include a system of disseminating health information to ALL citizens, but particularly to the elderly. The Council is very much interested in the apparent purposes of H.R.4472.

The Council participated in a recent needs assessment survey that brought together over a period of weeks a number of citizens of Orange County to discuss their needs and to evaluate them. Many senior citizens joined in the discussions. They made their needs known, and gave their priorities.

On the basis of that needs assessment project and from the Council's efforts to bring about the coordination of in-home health services, I have come to beleive that the best of professional personnel engaged in the delivery of health services are not necessarily effective either as designers of health systems or as implementors of programs that deviates from the status quo. Also, that enterdisciplinary efforts can be expected to be slow to come to grips with implementation. The consumers, themselves, seem likely to be the most effective force to bring about change. These observations influence the comments and recommendation that follow.

Recommendation:

The resolution should establish clearly just who is the primary target group.

The real target group is a sub-group of senior citizens-- Those who have a need or health information not readily available to them, either because of lack of education, sight, memory, mobility or suitable transportation, etc, or due to neglect of family or some other cause that isolates them from the

the information they need. For this group, or sub-group, to assimilate the information, it must be simple and graphic and, in most cases, presented on a one-on-one basis in the home by a person, or persons, who have access to the citizen in a continuing relationship. The "teacher" should be in a position to coordinate whatever health services result from that information.

Health professionals are NOT the primary target group. Their services are usually too expensive. In some instances there is a definite conflict of interest. They do have a place in the program, such as in the preparation or review of film strips and technical material, etc.

Hospitals and medical schools are NOT the primary target group. They, too, have a part, but often they seem more of the problem than the solution. Hospitals must understand the varied aspects of the problem and cooperate in the solution, particularly in the cure and abatement of desease. Medical schools must appreciate the problems of the elderly and train the medical profession to recognize and treat the ailments peculiar to, or more pronounced in, the elderly. More important, they must train the profession to accept the solutions. Nursing schools are a prime resource where the problems of the elderly are concerned. Not only are nurses more prone to accept change but their services are most important to the elderly. (In the needs assessment project referred to above, many elderly participants expressed their preference for a nurse practitioner over a physicion once a diagnosis has been made.)

The schools are NOT the target group. Teachers as professionals are not necessarily trained to deal with the real target group. For our purposes, a "teacher" is anyone who can be an effective purveyor of accurate information and who has access to the person in need of it. The schools can be helpful in teaching health generally and to their students in particular, but as for the sub-group of elderly who have the greatest need for health information, the information must ge specific with respect to the person's immediate needs and imparted by ANYONE trusted by that person.

In general: On the basis of the wording of H.R. 4472 and the testimony of many of the witnesses at the subject hearing, too much emphasis is placed on a long term health information program sparked by established schools and hospitals. Not enough emphasis has been placed on the immediate needs of the sub-group of senior citizens to whom existing information is not, for one reason or another, truly available. Graphic simplified materials would be helpful if "pitched" at a suitable level of understanding, but the impact of the proposed program can most effectively and quickly be realized by working directly with the various Departments of Aging and the elderly themselves.

Wil Morse

Wilbur L. Morse.
2023 Markham Dr.,
Chapel Hill, N.C.
27514

JAN 9 - 1984

THE UNIVERSITY OF ALABAMA
College of Education

Area of Health, Physical Education
and Recreation

January 5, 1984.

Mr. Ike Andrews,
2301 Rayburn House Office Building,
Washington D.C. 20515.

Dear Mr. Andrews,

A colleague of mine, Buzz Pruitt, editor of Health Education, a publication for the advancement of health education, has called my attention to the fact that you have introduced Bill HR 4472 in the House of Representatives. My understanding is that passage of HR 4472 will provide necessary resources for health education of Older Americans and that the process would involve educational institutions, dealing primarily with public health. This is a unique opportunity for the advancement of health education in the United States where our older citizens will reap many benefits.

As a health educator, and Center Associate to the Center for Ageing at the University of Alabama, I would like to offer my support of this Bill. In addition, I would like a copy of the Bill and pertinent literature relevant to its passage.

Bill HR 4472 is a long-awaited Bill. It is important, however that health educators as well as public health administrators play active roles in providing testimony at the Bill's hearings. Public health affiliates and health educators view health education somewhat differently and each employs different approaches and strategies to convey the concepts being taught. A prominent advocate of health education, Buzz Pruitt could provide testimony from the health educator's vantage as well as insights as to why health educators should be included in the development and implementation of health educations programs for our older citizens.

Good luck with Bill HR 4472.

Sincerely
Christine Nagy

A.B. MOORE HALL 205/348-6075 POST OFFICE BOX 1967 UNIVERSITY, ALABAMA 35486

JAN 9 - 1984

247 Country Club Road
Asheville, N.C. 28804
January 5, 1984

The Honorable Ike Andrews
House of Representatives
Washington, D.C. 20515

Dear Mr. Andrews:

We are interested in your bill to provide health education for the elderly, which you recently considered in hearings in Chapel Hill.

Will you please send us a copy of the bill or, at least, information about its provisions.

Sincerely yours,

Frederick H. Test

Frederick H. Test
Legislative Chr., Chap. 101
Amer. Assoc. of Retired Persons

JAN 1 0 1984

North Jeffco Metropolitan Recreation & Park District

9101 Ralston Road Arvada, CO 80002 303-424-7733 James F. Fisher, Executive Director

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6842 Wadsworth Blvd.
Arvada, CO 80003
425-9583

January 11, 1984

The Honorable Ike F. Andrews
U. S. Congressman
Chairman, House Human Resources Subcommittee
2178 Rayburn House Office Building
Washington, D. C. 20515

Dear Chairman Andrews:

This letter will express our concern with bill number 4472 which you are sponsoring.

Health problems faced by older persons can be eased and sometimes prevented with sufficient education and follow-up, however, these efforts should be concentrated on school age youth through middle aged adults so they will have an understanding of their own aging and health needs as they get older.

Senior Centers in our area are doing a superb job of not only educating older adults in these areas but of doing many hands-on health screenings. For example, regular blood pressure clinics, prescription drug checks and eye, ear and feet examinations, to name a few. We devoted an entire week in October, 1983 to Health Awareness when we had professionals in numbeous aspects of health care come in and directly interact with the seniors.

We feel strongly that the necessary resources, leadership and coordination required by this act will siphon funds needed for other essential senior services. Public Health agencies are already overtaxing their staff to perform health education and services for older adults. Evaluation of such a program would cost enormous quantities of money and be close to impossible to accomplish.

In conclusion, we strongly urge the defeat of H.R. 4472. States and local agencies are much better equipped to direct and oversee any programs relating to older adults.

Yours very truly,

Joanne S. Bacheldor

Joanne S. Bacheldor, Director
Senior Recreation Center

JAN 20 1984

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL

The School of Public Health
Department of Health Education

The University of North Carolina • Chapel Hill
Rosenau Hall 201 H
Chapel Hill, N.C. 27514

JAN 1 1984

January 12, 1984

Ms. Betsy Anne Lambe Reavis
Staff Assistant
121 Edinburgh South
Suite 205
Cary, N.C. 27511

Dear Ms. Reavis:

Please find enclosed comments Dr. Steckler and I would like to submit in respect to HR6472, the "Older Americans Personal Welfare Education Act."

Thank you.

Yours sincerely,

Guy W. Steuart

Guy W. Steuart, Ph.D.
Professor and Chairman

GWS:ajw

Enclosure

The Honorable Ike Andrews
U.S. House of Representatives

HR4472: Older Americans Personal Welfare Education Act

On behalf of ourselves and of the faculty of the Health Education Department, School of Public Health, University of North Carolina at Chapel Hill, we wish warmly to support the Older American Personal Welfare Education Act in respect both to its goals and to the general proposal for its implementation.

We believe such a program can be mounted at a relatively modest cost with the long term benefits holding great promise for considerably reduced costs in respect to morbidity, disability and medical care of older citizens of the United States.

In respect to the role of our department, we would expect no difficulty in securing the full and enthusiastic involvement of both faculty and students commensurate with our limited resources and the teaching, research and community service functions we are already performing. We would like to point out moreover that in our Master of Public Health program, students for almost the whole of the two-year period of study, are required to perform community service as a continuous learning function of the program. During this process they work with health and human service agencies in North Carolina as well as directly with community members and citizen groups. There will be no problem whatsoever about awarding graduate students credit for work they may do in respect to the health and welfare of the elderly since this is already an institutionalized procedure for meeting both masters and doctoral program requirements.

We have a few comments to make at this stage, most of which support or elaborate on suggestions already made by witnesses at the public hearing, held in Chapel Hill on December 20, 1983.

Firstly, we commend the notion of establishing pilot programs that can act as stimulators and as models that are within the scope and resources of more modest programs to emulate. In this respect, they could be used as training settings for other program coordinators and participants in which they may see and take part in demonstrably practicable and effective ways of applying the program. Very importantly, they could be used for the careful evaluation of steps and methods in more intensive ways than would be possible nationwide. Thus they would act as sources of tested and refined methods usable by other programs. Indeed they could and should be involved in developing simple

evaluation techniques. These would then be usable by other programs. This would enable the latter to have reliable means of judging the effectiveness of their own efforts on a continuous basis. It would enable them both to modify methods that are relatively ineffective and it would stimulate them to improve their performance.

Secondly, this evaluative aspect seems rather important because skepticism about the program and brakes on its momentum are likely to occur if we are unable to demonstrate that we are at least moving step by step in the direction of the intended goals and outcomes. Thus we feel it would be desirable to include a specific provision for some funding at least to be devoted to such evaluation which is unlikely to be done very well, and indeed be often neglected, unless there is a particular incentive and the needed resources.

Thirdly, we would like to emphasize a point we believe was made by Dr. Marian Solledar of the Association for the Advancement of Health Education in respect to a more active role for the elderly themselves. It would, we believe, be a mistake to frame the bill exclusively in terms of "experts" teaching the elderly as if this were to be a one-way process.

The elderly, as the intended beneficiaries of the program, themselves represent an extraordinarily rich pool of experience and indeed of expertise as to the needs and concerns of the elderly as well as to ways of communicating with and persuading their peers. Thus we need to build up in local communities a reservoir as it were, of elderly persons who have special experience and leadership skills and who could act as teachers of others. This approach has its own intrinsic merits quite apart from the problem of the limited numbers of expert personnel (or those who could be trained to be expert) likely to be available even over time. The number of such elderly persons who actively planned and contributed directly to the program would, we visualize, represent an increasing proportion of the total target population as the program progresses. Moreover, an important health principle is involved. A large part of the health problems of the elderly, both physical and mental, is one of feelings of helplessness and of dependence on others. The program should contribute to a feeling among the elderly that they are not as helpless as they appear to be and that they are able by their own organized efforts to help themselves. This group and communal effort will provide them with a sense of support and solidarity which then would be a major factor in the improvement of their health status.

Moreover, if the elderly are treated simply as passive recipients of a program over which they have no influence, they are unlikely to exhibit the kind of enthusiasm, support and advocacy of the program as it develops and which may ensure not only its success but its continuance.

We are ready to assist and to participate in every possible way and should you or your staff at any time wish specific consultation on any aspects of the program, please consider us at your service.

Yours sincerely,

Guy W. Steuart, Ph.D.
Professor and Chairman

Allan Steckler, Dr.P.H.
Associate Professor and
Deputy Chairman

GWS:ajw

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SCHOOL OF PUBLIC HEALTH

EARL WARREN HALL
BERKELEY, CALIFORNIA 94720

January 12, 1984

The Honorable Ike Andrews
Chairman
Subcommittee on Human Resources
Committee on Education and Labor
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Andrews:

I wish to congratulate you on introducing HR 4472 and offer my support and help in obtaining its passage. As a dean of a school of public health, I am well aware of the needs for increased efforts to provide the elderly with appropriate information to aid them in maintaining their health and independence. Health education programs carried out at senior centers is an excellent method for accomplishing this goal.

Please feel free to call on me and members of my faculty to aid you in any way you feel appropriate to obtain passage of HR 4472.

Sincerely,

Joyce C. Lashof, MD
Dean and Professor of Public Health

/rg

American Federation of Labor and Congress of Industrial Organizations

815 Sixteenth Street, N.W.
Washington, D.C. 20006
(202) 637-5000

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FEB 1 1984

January 12, 1984

Mr. Christopher Scott, President
North Carolin State AFL-CIO
Post Office Box 10805
Raleigh, NC 27605

Dear Chris:

I am in receipt of your letter dated December 22nd, concerning a bill introduced by Congressman Andrews, H.R. 4472, which provides health education for senior citizens. We have reviewed the bill and we find that it is meritorious, and a concept to which we could lend our support.

If you have any additional comments or questions, please don't hesitate to get in touch.

Sincerely,

Ray

Ray Denison, Director
DEPARTMENT OF LEGISLATION

JAN 19 1983

PO Box 5772
Raleigh, NC 27650
Jan. 14, 1984

Rep. Ike Andrews
2301 Rayburn House Office Building
Washington, DC 20515

Dear Rep. Andrews,

I have a suggestion that might be worth your research regarding health education for the elderly. Currently the Federal Government partially supports a nationwide network of radio stations via the Public Broadcasting System. It seems to me that a weekly half-hour to an hour publichealth educational program geared to the elderly could inexpensively be put together with medical school personnel and these stations. I would suggest this radio program in addition to clinical education programs. The advantage of the radio programs lies in their potential of reaching the most people with the least investment of time and resources. Secondly, it provides the immobilized with a source of preventive education.

Notification of programming, local stations and time of the program could be attained via flyers enclosed w/ Social Security checks, Medicare/Medicaid payments and certainly other routes of which I am unaware.

Thank you for your time.

Sincerely,
Lois Weingartner

JAN 26 1984

January 16, 1984

The Honorable Ike F. Andrews
House of Representatives
1319 Longworth House Office Building
Washington, D. C. 20515

Dear Congressman Andrews:

I am writing to urge that you withdraw your bill, H.R. 4472, that proposes a new Title VII of the Older Americans Act to add "personal welfare education and training" through senior centers.

Your proposed bill assumes that educational institutions of public health are necessary to establish health education in senior centers. This assumption is not correct. The Brighton United Senior Citizens Center (BUSCC) has a clinic available to provide seniors with additional health care. The philosophy of the clinic is one of wellness promotion. The goals are to assist seniors in maintaining as high a level of wellness as possible, to understand the illness they have, and to assist them in their own management of their illness. The services provided are meant to supplement the health care received from physicians and/or others---not to replace this care.

The health care is provided by a nurse practitioner and two nurse practioner students. The nurse practioner is a faculty member of the University of Colorado School of Nursing. Some of the services provided are: (1) teaching about one's medicines; (2) teaching and guidance in nutrition; (3) counseling and guidance regarding health promotion activities such as exercise, vitamins, sexuality, stopping smoking and enjoying oneself; and (4) teaching normal changes that come with growing old.

As you can ascertain, our senior center already offers quality health education programs. Therefore, we feel a new

The Honorable Ike F. Andrews
January 16, 1984
Page 2

Title VII of the Older Americans Act would be a duplication of services and require additional funds to support these existing services. Please review these facts and reconsider your proposal of bill H.R. 4472.

Sincerely,

Robert Burge

Robert Burge, Chairman
Board of Directors
Brighton United Senior
Citizens Center

RB/at

CC: Denver Regional Council of Governments

WELD CO.
COLORADO

DEPARTMENT OF HUMAN RESOURCES
PHONE (303) 353-0540
P.O. BOX 1805
GREELEY, COLORADO 80632

FEB 1 1984

January 24, 1984

The Honorable Ike F. Andrews
U. S. Congressman
Chairman House Human Resources
Subcommittee
2178 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Andrews:

I would like to express my concern about HR 4472. First I want you to know I am very supportive of personal welfare education and training through senior centers and senior nutrition sites; however, I believe you may not be aware that the education system is already in place in many counties in Colorado.

In Weld County I happened to be instrumental in setting up the educational system with our local junior college and Weld County Health Department. There is no charge to our program or people for this service. The instructor comes to each of our 20 nutrition sites and provides educational classes to our senior citizens 1 hour per week for 10 weeks. Our seniors are also able to receive 1 hour college credit for these classes. The classes have been very well received.

I believe if the bill is passed it would be a duplication of service. I feel this would take dollars from our program and decrease the number of people we may provide both services for.

I realize there are parts of the country that do not have such programs to tie into; however, I believe staff in many cases are not being as resourceful as possible.

Our project has been very successful and has utilized the community resources for our county.

Sincerely,

Bev Reid

Bev Reid, Director
Weld County Senior Nutrition Program

BR/sm

37-680 O—84——22

JAN 27 1984

ISOTHERMAL
PLANNING AND DEVELOPMENT COMMISSION
P. O. BOX 841
RUTHERFORDTON, N. C. 28139
287-2281

BILL WEAVER
Chairman
PAUL D. HUGHES
Executive Director

Executive Committee

Bill Weaver
Ned Gibson
Kathleen McMillan
Jack Harmon
Henry Demeron
Louise McGrath
Glen Rhodes

January 24, 1984

Mr. Ike Andrews, Member
U.S. House of Representatives
2201 Rayburn House Office Building
Washington, D. C. 20515

Dear Congressman:

This letter is in reference to House Bill 4472 which you introduced in the Congress. As I understand it, this bill will add a new title to the Older Americans Act to provide for health education and training of older Americans at senior centers throughout the nation through cooperative agreements with schools of public health. I commend you for this worthy endeavor; however, I am writing to make one suggestion concerning this proposal as it relates to the operation of senior centers.

At present, I am administrator of an Area Agency on Aging in Western North Carolina. We have five senior centers in our region supported, in part, by Older Americans Act money. Under the Older Americans Act, we may fund senior center operations. However, this budget can only include salary and travel for staff. There can be no operating costs such as supplies and utilities. This creates an administrative hardship on the director because he/she must prorate operating costs to several different program budgets. It appears to me that it would be much more efficient if the OAA were amended to allow Area Agencies to make a grant to senior centers for total operating costs. The grant, of course, would depend on the senior center meeting standards, developed by the National Institute of Senior Centers, the State Office on Aging, and the Area Agency. Included in the standards would be certain mandated services, one of which could be health education. This would mean the senior center would have only one budget to keep up with and would free the director to spend more time on program development, case management, etc.

As you know, N. C. Area Agencies will be instituting a new management system this year--Performance Based Contracting. However, Senior Center

Mr. Ike Andrews
Page 2
January 24, 1984

Operations will be exempt because there is no unit of service definition at present. If we could amend the Act to allow a total operations grant, then a unit definition and cost could be developed allowing us to be able to monitor more effectively.

I realize that this may be difficult to understand unless you actually work directly with senior centers. If you would like further comments, I will be happy to comply.

Again, thank you for your concern for the older citizens of North Carolina and the nation. I support you in your endeavor to pass House Bill 4472.

Best regards,

Diane

Diane Padgett
Aging Administrator

DP:mc

DRCOG FEB 6 1984 Denver Regional Council of Governments
Serving Local Governments Since 1955
7480 W. 26th Avenue
Suite 200B
Denver, Colorado 80211
303/455-1000

January 31, 1984

The Honorable Ike F. Andrews
U. S. Congressman
Chairman, House Human Resources Subcommittee
2178 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Andrews:

The purpose of this letter is to express our concern relative to H. R. 4472 which you have sponsored. The Denver Regional Council of Governments has two concerns about the bill:

(1) The proposed bill would duplicate existing services in our region, and
(2) H. R. 4472 could potentially siphon funds away from programs which are already underfunded.

The Denver Regional Council of Governments is the designated Area Agency on Aging pursuant to the Older Americans Act representing 52 percent of Colorado's older persons. DRCOG is concerned about spiraling health care costs for older persons, however, health screening and education will not prevent rising costs without other major changes in the medical care system. Despite our concerns, we believe health screening is a valuable preventive service for older persons. We also agree that the senior center network has the capability to successfully provide these services.

Nearly 60 senior centers in the eight-county Denver metropolitan area presently offer health screening for older persons. The services are provided by nurses from nursing schools, from health departments and home health agencies who donate their time. During 1984, DRCOG's Older Americans Act-funded centers will provide 7,885 units of health screening services to 2,644 older persons at 16 sites. This service network has developed over the past ten years with support from Older Americans Act funds through DRCOG, United Way and local governments.

BOARD OFFICERS
Thomas R. Eggert, Chairman
T.J. "Ted" Heckworth, Vice Chairman
Doris Durdy, Secretary-Treasurer
Vesta H. Miller, Immediate Past Chairwoman
Robert D. Farley, Executive Director

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Ken Lewis
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John P. Murphy
Federico Peña

The Honorable Ike F. Andrews
January 31, 1984
Page 2

Over 600 Area Agencies on Aging administer Older Americans Act programs in the U.S. Since the National Association of Area Agencies on Aging maintains a data base on services funded by Area Agencies, you may want to contact N4A in Washington, D.C. at (202) 484-7520 to determine the amount of health screening which is currently provided nationally.

If you need any additional information, please contact Susan Cockings Aldridge, DRCOG Aging Services Director.

Sincerely,

Robert D. Farley
Executive Director

clb

cc: Colorado Congressional Delegation

The Congress of California Seniors

STATE AFFILIATE NATIONAL COUNCIL OF SENIOR CITIZENS, WASHINGTON D.C.

Region IV FEB 10 1984

P.O. Box 5015, San Jose, CA 95150

FROM THE SAN JOSE OFFICE OF

PRESIDENT: Herb Goldblum

February 5. 1984

THE HONORABLE CONGRESSMAN
IKE ANDREWS

Rayburn Office Bldg.
Washington D.C. 20515

Dear Congressman Andrews:

Enclose please find copy of a "Resolve" of an Assembly of elder Senior Citizens, Dec. 13, 1983 concerning themselves with the Re-Authorization of the Older American Act of 1965 and its Amendments,1978/80.

Everybody was impressed by H.R. 4472 and pledged full support if needed. It sounds so natural, that we cannot understand why the possibilities of Medical Cost Containments were not explored earlier as your Bill 4472 suggests.

At this moment the officers of Region IV, Congress of California Seniors, are active to publicize H.R. 4472 in our 5 Congressional Distr. We are contacting our Congressmen: Edwards, Mineta, Panetta, Zschau, Lantos.

We are all eager to hear from you, if your are "moving" through the Committees?

Respectfully HERBERT GOLDBLUM

REGION IV
DISTRICT 1, MONTEREY • DISTRICT 2, SAN BENITO • DISTRICT 3, SANTA CRUZ
DISTRICT 4, SANTA CLARA • DISTRICT 5, SAN MATEO

The Congress of California Seniors

STATE AFFILIATE NATIONAL COUNCIL OF SENIOR CITIZENS, WASHINGTON D.C.

Region IV

P.O. BOX 7361 SAN JOSE, CA., 95125

PRESIDENT: Hugh Culbertson

+++++++

R E S O L U T I O N

WE, THE ELDER CITIZENS OF SANTA CLARA COUNTY, CALIF. IN A PUBLIC HEARING ON THE RE-AUTHORIZATION OFTHE OLDER AMERICANS ACT RESOLVED TO SUPPORT IN FULL H.R. 4472 (CONGRMAN IKE ANDREWS, N.C.) AND WORK FOR THE ENACTMENT INTO LAW.

AND IT IS FURTHER RESOLVED:
TO INVITE CONGRESSMAN ANDREWS TO A PUBLIC HEARING IN SAN JOSE, TO BE HELD AT THE CYPRESS SCHOOL, SAN JOSE.
IT WAS RESOLVED WITH THE AMENDMENT:
" TO CALL ON OUR & NEIGHBOR DISTRICT CONGRESSMEN TO PARTICIPATE.

GERRY BERNHARD, SENIOR CENTER, DECEMBER, TUESDAY 13, 1983
SIGNATURES OF ASSEMBLY ATTACHED

Congress of California Seniors Region IV

and

CASA SENIORS ADVOCATES

National Council Senior Citizens

SENIORS TO THE CHALLENGE

PUBLIC HEARING

ATTENDANCE LIST:

PUBLICITY SEMINAR OLDER AMERICAN ACT, 1985 reauthorization

DECEMBER 13, 1983

Name	Address	Zip	Phone #
[illegible]	787 Allison [illegible]	[illegible]	736 1738
Judd Ingram	Catholic Soc. Services 2155 The Alameda, S.J.	95126	243-3001
Angelia Jones	West Valley Sr. Center 1491 Bollinger Rd. Cupt.	95014	996-7210
Bill Chen	55 W. Younger Ave, S.J.	95110	249-2155
Bruce Pardella	55 W. Younger, S.J.	95110	279-3464
Eleanor Simmons	4363 Payne Ave #911		984-7916
Eunice Kunzel	4341 Payne Ave, #606		246-1088
Harriett Johnson	4331 Payne Ave #520		247 7916
Hamer Johnson	4331 Payne Ave #520		247-7916
Mabel Reeves	4329 Payne Ave #472		244-6126
Ella B. Rodinsky	4363 Payne #911		244 6018
Margaret McFarlane	4341 Payne Ave #620		246-9962
Mary C. Robinson	Cupertino Sr. Ctr		253 2075
Inge Denberg	4321 Payne Ave #319		244-0273
Betty Rogers	4329 Payne Ave #8		
Velma Watt	4747 Atherton Ave.		375-0309
Miguel B. Donoso	1256 Simonson Ct.		225-1166
Florence Pockel	4341 Payne apt 619		249 8344
Helen Bennett	4341 Payne Ave Apt 619		244 7864
Serena Scott	4329 Payne #401		244-6131
Loren Murphy	4353 Payne #715		247-8952
[illegible]	2181 The Alameda		246-8290
Mae Walker	4363 Payne Ave #806		249-4042
Joseph Carpenter	1333 Saratoga Ave		255-4419
[illegible]	4363 Payne Ave #818		246-2755
Rosemary Wallace	4853 Blue Ridge Dr		252 0664

Name	Address	Zip	Phone #
John F. Lydon	2705 Homestead Pkwy Santa Clara	95051	244-9746
James M. Hurley	1143 El Solyo, Campbell	95008	377-2835
John P. Colman	8891 Riding Way Sanjer	95135	271-7804
Frank Freeland	429 Dunster #2 Campbell	95008	369-078.
Angelina Yates	1258 Gainesville Ave	95122	258-0123
Phyllis B. Dolloff	P.O.B. 695, Saratoga,	95071	867-3785
Norman H. Dolloff	POB 695 Saratoga,	95071	867-3785
Rose Spear Modell	1170 Huntingdon Dr. S.J.	95129	243-9158
Mildred Bruf	15158 Chelsea Dr S J	95124	377-5588
Eileen Bruf	" " " "	"	" "
Edward C. Ritter	15229 Dickens Ave, S.J.	95124	371-22.
Edward T. Johnson	16159 Lonetta Bend Hill	95030	356-94.
Marjorie Hilton	20309 Saratoga Vista	95070	741-5276
C.A. Joyce	1018 Duncan Ave Sunnyvale	94089	734-0615
Chuck Doty	1751 Creek Dr San Jose	95125	267-5835
Frances Consalvi	447 Holden Ave S J C.	2430239	
James Ashley	4346 Payne Ave Apt 805	246-4837	
Jerry Bernhard	4333 Colombo Dr S J	95130	243-2773
[illegible]	2648 Kimball Dr		225-6567
James Johnson	4331-520 Payne Ave		247-7516
Virginia Carson	14520 Fruitvale B201		867-0386
Al Kerner	4950 Cherry Ave San Jose		266-3734
Hal Janzen	1566 Lupton Ave " "	95125	998-4019
Frank E. Mulera	4833 Blue Ridge Dr	95129	252-486
Alomia Noyes	4331 Payne 511		244-8402
Eleanor Fitzieri	4341 Payne		
NINA SANTOMIERI / CONGRESSMAN MINETA	1245 S. WINCHESTER		984-604
Margarita Segura / Assemblyman Vasconcellos	100 Paseo de San Antonio #106 S J		288-761
Eimi Okano	Supv. Becky Morgan Ofc 70 W. Hedding SJ	95110	299-2823
Tim Jenkins	701 Ocean St, Santa Cruz - Sem. Millbrook	425-04	

1-26-89 Resolve:
H.R. 4472

"FORUM" — FEDERATION — OF — RETIRED — UNION — MEMBERS

Name	Address	Union	Phone
Phyllis Ward	1806 Kirkley Av. S.J.	SEIU 535	265-1554
Francis G. Fink	118 Azucar Ave. SJ.	ILWU #6	227-3840
Mike Krzynick	760 Emory St.	Local 3	266-7502
Herschell Morgan	1601 Knollwood Ave. #1755		264-7294
Eddie White	45229 Dickens Av. S.J. #392		351-2200
Ed Johnson	16159 Longitta Lane L.G.	ILWU 392	356-9402
Oscar Hart	636 Kenneth Ave. Campbell	ILWU #6	378-0[illegible]
Carlo Mora	795 Bauth St S.J.	SEIU 250	287-3030
Richard Finlayson	1415 Stockbridge Dr San Jose Calif 94130	SM 309 Govt.	248-7469
Jeff Boehne	152 S. 16th, S.J. 95112	New Guild	98
[illegible] Nelson	887 N 7th 95112	Machinist Dist 93	
Cassidy Germen	700 N. Capitol Av. SJ 95133	SEIU 915	259-1765
Charlotte Suskind	426 Boynton Ave. #120 S.J. 95117	RSSA	246-5008

New delegate to FORUM mail list

The Congress of California Seniors

STATE AFFILIATE NATIONAL COUNCIL OF SENIOR CITIZENS, WASHINGTON D.C.

Region IV

(408) 279-0966 P.O. BOX 7361 SAN JOSE, CA. 95150 (408) 279-0966

PRESIDENT: Nick Galifianakis

IN SPONSORSHIP
WITH

National Council of Senior Citizens

CALL FOR 4th

PUBLIC HEARING

Reauthorization legislation for the Older Americans Act

1:30 P.M.

FRIDAY, FEBRUARY 24, 1984
CYPRESS SENIOR CENTER
403 S. CYPRESS AVE., SAN JOSE

1:30 P.M. (SHARP)

PRINCIPAL MODERATOR: JOHN RIGGLES, EX. DIRECTOR, STATE COMMISSION ON AGING

" HISTORY OF OLDER AMERICAN ACT, 1965"
" WHY PUBLIC HEARINGS?"
" WHAT IS SO IMPORTANT TO GET INVOLVED?"
" WHY BOTHER?" WHY ME?".....I have retired!

MR. RIGGLES WILL CO-CHAIR with ERNIE LENT, CAL.SEN.LEGISL LECTURER and EDUCATOR, A DISTINGUISHED PANEL OF CAL. LEGIslators, CAL. SEN. LEGISLATORS, STATE COMMISSIONERS AND RESOURCE STAFF PERSONEL FROM THE OFFICES OF CONGRESSMEN: EDWARDS, MINETA, ZSCHAU, PANETTA, LANTOS. (INVITED)

TRANSPORTATION: BUSES 23 + 24. STOPS AT THE CORNER OF "CYPRESS" and "STEVENS CR.BL" ACCESSABLE FOR HANDICAPPED

INFORMATION : N.C.S.C. 408-279-0966
I.&R. 408-243-8570
san jose sen. information 408-683-4111

" 1 1/2 block by fo or chair."

FOOD : DO N O T BRING BROWN-BAG! N.C.S.C. # 3919 WILL SERVE REFRESHMENTS FROM 12:15 P.M. (IN STYLE OF THE HOSPITAlity ROOM AT THE C.C.SENIORS CONVENTION)

FEB 10 1984

February 9, 1984

ASPH
ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

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Dean, School of Public Health
University of Alabama-Birmingham
Vice President
Edyth Schoenrich, M.D., M.P.H.
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Johns Hopkins University
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Yale University
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Michael K. Gemmell
Associate Director
Mary Lou Lickwinko, M.H.S.A.

1015 FIFTEENTH ST., N.W.
SUITE 404
WASHINGTON, D.C. 20005
202-842-4668

The Honorable Ike Andrews
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

In my travels to the Schools of Public Health and discussions with the Deans, I've found unqualified support for your bill (H.R. 4472) to provide health promotion and disease prevention services to senior citizens centers. The Deans will be meeting in convention in Charleston on April 5-6 and will pass a resolution endorsing the bill. If we can do more to marshall support for H.R. 4472, please let us know.

Given your interest in prevention, ASPH President Bridgers has asked me to send you a copy of his proposal to create a trust fund to support prevention services in this country. He would very much like to discuss this with you at your convenience.

Again, Mr. Chairman, ASPH applauds you for your efforts on behalf of the public health, health promotion, disease prevention and gerontology fields.

Sincerely,

M Gemmell

Michael K. Gemmell
Executive Director

cc: Dean Bridgers

mlc

FEB 24 1984

February 19, 1984

Representative Andrews
Rayburn House Office Building, Room 2201
Washington, D.C. 20515

Dear Representative Andrews:

I am writing to applaud your introduction of H.R. 4472, the bill to amend the Older Americans Act of 1965 by adding health education and training at the multipurpose senior centers. As a public health nutritionist, I am well aware of the savings that can be accrued through health promotion and illness prevention, especially in light of rising medical costs. Your proposal demonstrates admirable foresight and I feel that, if implemented, it would show very favorabl results for both the government and individuals in a long range cost-benefit analysis. In addition to monetary benefits, one can predict immeasurable improvements in the quality of life for many older Americans participating in this program.

My own experiences with the people in the Title III feeding program confirm your suggestion that multipurpose senior centers are appropriate points of contact. The seniors have demonstrated to me an eagerness to learn and a hunger for educational presentations. I feel that a coordinated, standardized program aimed at their specific health problems and needs would be well accepted and utilized.

Based on my knowledge of health and nutrition throughout the life cycle, I respectfully request that you reconsider the wording of section 704(b), item (1)(D) regarding education components. Presently it suggests diet as one component. Recent research has shown that nutrition plays a significant role in determining the health status of the elderly. It has also been shown that nutrition education as a part of group feeding programs has resulted in improved eating habits and a greater knowledge of nutrition for the participants. Caliendo's 1980 evaluation of the National Nutrition Program for the Elderly revealed that nutrition knowledge significantly influenced the nutritional benefit derived by meal participants. I request that in view of such evidence, the bill require nutrition as an educational component.

As a resident of Chapel Hill and a voter in the 4th Congressional District of North Carolina, I am proud to have a representative who is sensitive to the needs of an often forgotten segment of our population, the elderly. Given your concern for older Americans, I am confident that you will recognize the value of requiring nutrition education in H.R.4472 and I look forward to the passing of this bill.

Sincerely,
Lynn Sinclair
Lynn Sinclair
525 Hillsborough St. Apt. 1
Chapel Hill, NC 27514

FEB 2 1984

Robin J. Medina
Dept. of Nutrition, School of Public Health
University of North Carolina
Chapel Hill, N.C. 27514
Feb. 20, 1984

The Honorable Ike Andrews
Chairman, Subcommittee Human Resources
United States House of Representatives
2178 Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Andrews:

I would like to express support for the following bill: H.R. 4472, "Title VII- Older Americans Personal Welfare Education and Training Program." As a nutritionist, I take particular interest in this legislation in view of its nutritional implications. Several provisions of this bill target the nutrition related problems of older Americans.

Public health nutritionists and dietitians have long recognized the prevalence of poor dietary practices among the elderly. Numerous studies and surveys confirm these observations. Unfortunately, these habits manifest themselves at an age when individuals are particularily vulnerable to nutritional deficiencies and chronic disease conditions with nutritional implications. Although poor nutrition in this age group is due to many reasons, low education is frequently sited as a contributing cause. Studies indicate that nutrition education programs for older Americans have been successful in increasing nutrition awareness, as well as improving knowledge of nutrition and food selection. Specific objectives for disease prevention and health promotion through nutrition education have been published in the U.S. Department of Health and Human Services publication, Promoting Health/Preventing Disease. Objectives for the Nation.(1980). This bill certainly provides the means to begin to accomplish these objectives.

I believe, as do numerous professional organizations, including the American Dietetic Association and the American Public Health Association, that it is in our nations best interest to help prevent disease and disability through health education for older Americans.

Sincerely yours,

Robin J. Medina

Robin J. Medina
MPH Candidate

FEB 23 1984

Family Practice Residency Program
430 Biltmore Avenue Asheville, NC 28801-4596 704/258-0670

February 20, 1984

Representative Ike Andrews
Chairman, Subcommittee on Human Resources
Committee on Education and Labor
U.S. House of Representatives
Room 217 B, Rayburn House Office Building
Washington, D.C. 20515

Dear Representative Andrews:

Thank you for your letter concerning the material that MAHEC has developed, "A Healthy Age" and for a copy of H.R. 4472. The slide/tape show and discussion material has been made available to each of the 16 county health departments in our western MAHEC region, with an additional six copies available through the state library in Raleigh. Dr. Bacon, MAHEC Executive Director, is arranging with Sandi Payne, of your Chapel Hill office, to make this material available to you.

MAHEC is presently seeking funding support to expand the span of topics covered, broaden the cultural appeal and to develop a video format to supplement that of the slide/tape show. To date, we have found this material very useful in initiating discussion with older citizens and in stimulating them to gain more control of their health and health care resources. Much remains to be done, but this has been a rewarding start for us.

Our Family Practice Residency and Family Nurse Practitioner Programs devote a significant portion of curriculum time to the care of the elderly, health promotion and disease prevention. We presently share, with UNC-A, a Kellogg Foundation Grant for the implementation of an experimental health promotion program training both students and residents. Dr. P. R. Olson, the director of our residency, also heads up the Division of Geriatrics/Gerontology at MAHEC and this area figures prominently in our recently completed 5 Year Plan.

The Academy of Family Physicians, with it's 56,830 members, and the American Board of Family Practice, with it's 388 residency training programs and 14,967 graduates, have a strong commitment to the areas addressed in your Bill H.R. 4472 -- the care of the elderly and health promotion/disease

prevention. I am certain that these widely dispersed resources stand ready to assist the schools of public health in both curriculum design and service delivery. This type of cooperative effort certainly has been successful here in our own state AHEC and university system.

I was very excited to receive your letter and learn of H.R. 4472. Your efforts and commitment to this cause are much needed and greatly appreciated. If I can help in any way, I would be most honored.

Sincerely,

Richard F. Walton MD

Richard F. Walton, M.D.
Professor of Family Medicine
MAHEC

RFW/cjv

cc: Gene Mayer, M.D.
Tom Bacon, Ph.D.
P.R. Olson, M.D.
John Frey, M.D.
Sandi Payne

Enclosures

THE W.K. KELLOGG GRANT

TO UNC-ASHEVILLE/MAHEC FOR A HEALTH PROMOTION PROGRAM

In July of 1982 the W.K. Kellogg Foundation of Battle Creek, Michigan, announced a four-year grant award of $592,000 to UNC-Asheville for a Health Promotion Program to be developed at UNC-Asheville in conjunction with the Mountain Area Health Education Center (MAHEC). At UNC-Asheville, the program will emphasize health promotion as a part of the liberal arts curriculum, supported by credit and non-credit group activities. At MAHEC, the program will include training of Family Practice Resident Physicians in health promotion methods as a part of primary medical care. The MAHEC faculty and resident physicians will play an active part in the design and delivery of the program at UNC-Asheville.

At UNC-Asheville the program features an innovative liberal arts course in health promotion and human potential, housed within the Psychology Department. For three semester hours credit, the course includes an emphasis upon (1) personal fitness, via aerobic conditioning; (2) knowledge and skills regarding stress and stress management; (3) interpersonal relationships as related to health and health promotion. Other subjects and support group activities will include personal choices, and behavior and values clarification related to individual health, e.g., smoking, nutrition, weight control, and personal safety.

As time allows the course will address additional social and cultural issues, such as the costs of health care, life-support decisions in terminal illness, and the sick role. All students will learn basic information about body systems highly related to personal fitness, individual choices and health: such as cardiovascular, immunological and endocrine systems, and the human brain.

Students will experience education in several ways: through lectures and films; through small "laboratory" discussion groups; through an individual aerobic health promotion experience; through an individual health promotion conference with a resident family physician; and through a personal health risk appraisal and a personal health contract.

At MAHEC family practice faculty will avail themselves of a series of teaching visits by physicians from across the United States who are significantly involved in both clinical practice and health promotion. These visits will include a conference series, the collection of a videotape library of these physicians working with patients, and turnabout precepting of faculty with consultant physicians for faculty development purposes, wherein consultant and MAHEC faculty members will watch one another's patient visits and discuss them.

The conference series will include information about a Health Hazards Appraisal and primary care; exercise, sport and health; interpersonal relationships and health; health promotion in the office setting; and stress and stress management for physicians and patients.

The Program Team is led by the grant and program director. The team includes a full-time campus coordinator, a family practice medical faculty member, a resident physician, an evaluation coordinator, an affiliated part-time physical education instructor, and a secretary. These individuals are:

William E. Bruce, Ph.D., Director
M. Walker Buckalew, Ph.D., Program Coordinator
Roxann Schafhausen, M.S., Physical Education
Richard F. Walton, M.D., MAHEC faculty
Bruce Kelly, M.D., Resident, MAHEC
Joe A. Suddeth, M.A., Evaluation Research Assistance
Linda Lisnerski, Program Secretary

This team includes expertise in the areas of family medicine, behavioral health and medicine, exercise physiology and conditioning, stress and related subjects. Other UNC-Asheville and MAHEC faculty provide consultation, critique and professional services to the program.

The Future. The University of North Carolina at Asheville has agreed to gradually assume financial responsibility for the program: MAHEC expects to feature health promotion as an element of uniqueness and excellence in the Family Practice Residency Program. The Kellogg Foundation Grant will provide for development, equipment, delivery and dissemination costs for a period of four years.

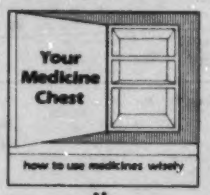
Origins of the Grant Proposal date to 1980. Co-authors of the grant proposal were Dr. Bruce, Dr. Eric V. Iovacchini, UNC-Asheville, and Dr. Donald M. Cassata, UNC-Chapel Hill. As Vice Chancellor for Student Affairs at UNCA, Dr. Iovacchini is responsible for the interfacing of the Health Promotion Program, with other related departments in the Division of Student Affairs. Dr. Cassata continues as development consultant to the program. The application process was ably supported by many individuals at UNCA, MAHEC and UNC-Chapel Hill.

37-680 O—84——23

A HEALTHY AGE

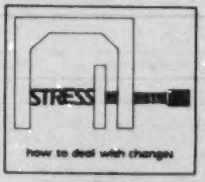
A Series of Health Activation Packages for Older Persons

I & VII



II

III



IV

V

VI

Each series of A HEALTHY AGE contains curriculum materials for conducting seven 90-minute sessions on health activation for older adults. Included are six sound/slide programs, seven session plans, and seven leader's guides. The session plans outline each program step by step and use methods such as group discussion, role play, physical activity, handouts, and homework to assure participant involvement.

[redacted] entire series $588.
[redacted] per session $105.
[redacted] preview (may be applied to purchase) $10.

Please send me A HEALTHY AGE

Mountain Area Health Education Center
501 Biltmore Avenue - LRC
Asheville, NC 28801
(704) 258-0881

☐ Preview for purchase consideration
☐ Purchase entire series
☐ Purchase (circle one or more)
I II III IV V VI

$_____ enclosed

Name_____ Phone ( )_____

Organization_____

Address_____

City_____ State_____ Zip_____

AAFP REPRINT NO. 150

JULY, 1983
RESULTS OF THE ANNUAL SURVEY
FAMILY PRACTICE RESIDENCY PROGRAMS

AMERICAN ACADEMY OF FAMILY PHYSICIANS

I. PROGRAMS

A. TOTAL ACCREDITED PROGRAMS — 388

1. NEWLY ACCREDITED PROGRAMS THAT HAVE NOT YET ACCEPTED RESIDENTS — 2

B. PROGRAM STRUCTURE TYPES

1. COMMUNITY HOSPITAL BASED	40
2. COMMUNITY BASED & MEDICAL SCHOOL AFFILIATED	211
3. COMMUNITY BASED & MEDICAL SCHOOL ADMINISTERED	56
4. MEDICAL SCHOOL BASED	64
5. MILITARY PROGRAM	17

II. RESIDENTS

A. TOTAL RESIDENTS — 7,409

1. TOTAL FIRST YEAR RESIDENTS	2,549
2. TOTAL SECOND YEAR RESIDENTS	2,520
3. TOTAL THIRD YEAR RESIDENTS	2,344

B. TOTAL APPROVED FIRST YEAR POSITIONS — 2,628

C. FIRST YEAR FILL RATE — 97%

D. INCREASE/DECREASE CLASS SIZE BY YEAR

	1981-82	1982-83	1983-84
CLASS OF '84	2,489	2,413	2,344
CLASS OF '85	-----	2,578	2,520
CLASS OF '86	-----	-----	2,549

III. RESIDENCY GRADUATES

A. TOTAL JULY, 1983 RESIDENCY GRADUATES — 2,133

B. TOTAL GRADUATES FROM FAMILY PRACTICE RESIDENCY PROGRAMS SINCE JANUARY 1, 1970 — 14,987

8/8/83
CE

WASHINGTON
MONTANA
NORTH DAKOTA
MINNESOTA
OREGON
SOUTH DAKOTA
WISCONSIN
IDAHO
WYOMING
NEW YORK
CALIFORNIA
NEVADA
UTAH
NEBRASKA
IOWA
MICHIGAN
ILLINOIS
INDIANA
OHIO
PENNSYLVANIA
N.J.
DEL.
MD.
W. VA.
COLORADO
MISSOURI
KANSAS
VIRGINIA
KENTUCKY
ARIZONA
NEW MEXICO
OKLAHOMA
ARKANSAS
TENNESSEE
NORTH CAROLINA
TEXAS
S. CAROLINA
LOUISIANA
MISSISSIPPI
ALABAMA
GEORGIA
FLORIDA
ALASKA
HAWAII
PUERTO RICO
American Academy of Family Physicians

AAFP Reprint No. 1881

American Academy of Family Physicians

REPORT ON SURVEY OF 1983 GRADUATING FAMILY PRACTICE RESIDENTS

The total number of graduates surveyed was 2117. Of this number 1632 (77%) responded. Of these respondees, 1891 indicated the type of practice arrangement and 1383 specified the size of the community in which they plan to serve. A summary of the results as of July 1983 follows.

The data from 1977, 1978, and 1979 has been re-analyzed to conform with the 1980-1983 statistics. Caution must be exercised in comparing data previous to 1977 because of changes made to data analysis. However, the revised 1977-1979 data may be directly compared with the 1980-1983 data with confidence.

PRACTICE ARRANGEMENTS OF 1983 GRADUATING RESIDENTS

Type of Practice Arrangement	Number of Reporting Grads	Percentage of Total Reporting Grads
Family Practice Group	338	21.1%
Multi-Specialty Group	154	9.7%
Two-Person Family Practice Group (Partnership)	245	15.4%
Solo	264	16.9%
Practice (arrangement not specified)	43	2.7%
Military	121	7.6%
Teaching	62	3.9%
USPHS	133	8.3%
Emergency Room	97	6.1%
Hospital Staff	26	1.6%
Research	4	.3%
Administrative	1	.1%
Further Training	30	1.9%
Fellowship	30	1.9%
None of the above	56	3.5%
	1,591	100.0%

DISTRIBUTION OF 1983 GRADUATING RESIDENTS BY COMMUNITY SIZE

Character and Population of Community	Number of Reporting Grads	Percentage of Total Reporting Grads	Cummulative Percentage of Total Reporting Grads
Rural area or town (less than 2500) not within 25 miles of large city	112	8.2%	8.2%
Rural area or town (less than 2500) within 25 Miles of large city	26	1.9%	10.1%
Small town (2500-25,000) not within 25 miles of large city	342	25.1%	35.2%
Small town (2500-25,000) within 25 miles of large city	191	14.0%	49.2%
Small city (25,000-100,000)	246	18.1%	67.3%
Suburb of small metropolitan area	40	2.9%	70.2%
Small metropolitan area (100,000-500,000)	122	9.0%	79.2%
Suburb of large metropolitan area	146	10.7%	89.9%
Large metropolitan area (500,000 or more)	81	5.9%	95.8%
Inner city/low income area (500,000 or more)	57	4.2%	100.0%
	1,363	100.0%	

CE 7/18/83

MAR 13 1984

UNIVERSITY OF MINNESOTA
TWIN CITIES

Department of Graduate Studies in
Social and Administrative Pharmacy
College of Pharmacy
308 Harvard Street S.E.
Minneapolis, Minnesota 55455

March 2, 1984

Representative Ike Andrews
Room 2178 Rayburn HOB
Washington, DC 20515

Dear Chairman Andrews:

I am writing in regard to your multi-purpose senior center initiative which I understand is included in HR 4472. Your representative who was speaking at the closing session of the Drug Information Association workshop on geriatric drug use mentioned the interest in including educational efforts specifically directed at improved use of medications. I applaud your efforts. While I have not seen HR 4472 and thus am unfamiliar with the particulars of the bill I have given some thought to providing drug education to the elderly through the existing senior center network.

I am presently completing my doctoral dissertation at the University of Minnesota and am studying the issue of medication information-seeking by older adults. The thoughts I would like to present in this letter reflect some theory development on my part as well as my thinking on improving the aging drug use process.

The literature on geriatric drug use, as you are well aware, is overwhelming. Volumes have been written and numerous seminars have been held on drug use and misuse by the aged. In part I feel the issue has been exaggerated, yet I do not mean to minimize its importance. While people over 65 years of age consume a disproportionate quantity of prescription medications the vast majority either take no medications or rely on 1 or 2 chronic prescription products for the maintenance of their health and well-being. Most senior citizens are well-informed as to the name, purpose and important side effects of the medications prescribed for them and actively seek information about these drugs to enhance their health.

A disservice is being performed by those who "homogenize" all older adults and classify them as a drug misusing portion of society. By using averages and generalizations an equal but opposite disservice is done those who do have significant drug-related problems. I have estimated that perhaps 10-15 percent of the aged population is in need of assistance or special attention for the management of their drug therapy. This segment has been overprescribed, underprescribed, misprescribed, undereducated, overwhelmed and/or ignored. This is the group I refer to as people truly at risk of negative health consequences because of their medications and at risk of iatrogenic illness,

institutionalization and even death because of drugs. This is a public health problem of major concern.

The problem we all face (health care providers, researchers and public policy makers) is identifying those in need of assistance before they appear in our hospitals and nursing homes. This is the focus of my research. I believe the senior center has merit as an indirect point of access to these people. I will stop short of delving into the specific details of my dissertation to support my contentions but my preliminary results indicate that the people we are interested in finding do not self-identify. The people who will come to any senior center program on prescription and nonprescription drugs will mostly be astute, concerned and curious individuals who are interested in enhancing their knowledge, both general and specific, on an issue with tremendous health implications. They will ask your speaker, who I believe should have some pharmacy training and experience, about generic drugs, vitamins and sources of drug information. These people will benefit from any educational efforts, however the seniors with serious drug problems probably will not participate.

I have not yet satisfied my curiosity as to why those in need do not self-identify but I have learned one thing pertinent to this initiative. This is the theoretical issue I hope you will keep in mind. Each of the individuals attending the senior center program will have one thing in common. Regardless of their own state of medication use and understanding the people participating will have a story about "a friend" who can not control his/her drug regimen. In this case I do believe it is really the friend and not the first person with the problem. It might be a sister, neighbor, friend or spouse.

This finding has suggested that an appropriate tack for a senior center program is one of recognition and referral. Teach the attendees the importance of recognizing drug related problems before it is too late. An important element of such a program would be the identification of sources of assistance for purposes of referral.

My only hesitation in recommending this and following through with program development comes from a concern that such an effort would be viewed too closely as a police-type initiative. Using friends and loved ones as sources of referral does have potential problems. Given the health and economic implications of not identifying individuals in need of assistance my concern is probably a minor one.

The above provides a capsule of my thinking on an issue that deserves a great deal of attention. There are many model programs of drug education in senior centers and highrise apartments. Retired and practicing pharmacists and pharmacy students have been active in this arena for years. I have spoken to the national staff director of the Student American Pharmaceutical Association and will soon discuss this issue with the national officers of this group representing 12,000 pharmacy students. I am suggesting that this senior center initiative might be a good project opportunity for the 72 Student APhA chapters in the nation's colleges of pharmacy.

I would appreciate receiving a copy of HR 4472 and any other information pertinent to this issue. Thank you for seeking my comments on the topic. Should you want any clarification on the points I have presented or any other information I will be happy to supply them. My mailing address will remain the same (308 Harvard St. S.E , 7-158, Minneapolis, MN 55455) even after I have completed this dissertation research project.

Sincerely,

Lucinda L. Maine

Lucinda L. Maine, Doctoral Candidate
Kellogg Clinical Scientist Program

C. Shannon
100 A Cocheco St.
Dover, NH 03820

Mar. 6, 1984

Rep. Ike F. Andrews
House Education and Labor Human
Resources Subcommittee
House Ofc. Bldg.
Washington, D.C. 20510

Dear Mr. Andrews:

I am writing to support your efforts to add a Title VII to the Older Americans Act (H.R. 4472), that would mandate health education (including nutrition) and training. In addition, the American Dietetic Association has come out with positions regarding reauthorization of the Older Americans Act that would be supportive of your work. I have strong feelings regarding Nutrition Education. As far as mandating it is concerned, I have worked with the NET and WIC Programs, and attest to the cost-effectiveness of these programs with minimal investment. These programs work; no staff person has to worry wether food dollars are competing against education dollars!

My experience has shown that nutrition education is best accomplished by one-to-one counseling, demonstration and

participant involvement in group activities. Merely giving out information (as is currently the case in most elderly feeding programs) is ineffective. People need help in relating "information" to something in their lives or health situation. My experience with Southeast Asians in the WIC Program has emphasized the importance of tailoring nutrition education for ethnic groups using traditional, familiar and available foods. We don't have much information regarding nutrient needs of the elderly; this makes them easy prey for "faddists". I have personally observed elderly persons purchasing bottles of nutritional (?) supplements. A little counseling could give them the ability to choose - or refuse - wisely (and save money!).

Nutritional services are integral components of a preventative medical system. Proper attention to diet, nutrient-drug interactions and provision of adequate food period can save money on hospitalizations in this population. The services of a registered dietitian may be extended by: trained peer counselors, volunteers, or use of the system that the EFNEP Program employs (aides work with low income families in their homes to deliver nutrition information).

I hope my comments prove helpful to you as you make decisions on nutrition services for the elderly. Cost-saving, health-promoting measures can only become more important as medical costs increase together with the numbers of elderly requiring them.

Sincerely

Christine A. Shannon MS, RD.

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL

School of Pharmacy

The University of North Carolina at Chapel Hill
Beard Hall 300 H
Chapel Hill, N.C. 27514

March 14, 1984

Gordon Raley, Ph.D.
Specialist, Elderly Care
Office of Senator Ike Andrews
2201 Rayburn House Office Building
Washington, DC 20515

Dear Dr. Raley:

Thank you for your receptiveness to our study proposal. As we discussed in our phone conversation, the goal of the study is to prevent medication problems in the 30,000 elderly being cared for by North Carolina Domiciliary Care Facilities; a topic very much similar to the issues raised by Senator Andrews. Research in the area of prevention of medication problems by the elderly will make an important and practical contribution to "healthy aging" of the elderly North Carolinians. We hope to receive Senator Andrews' endorsement for this grant proposal. This endorsement will be added to the grant submitted to the National Center for Health Services Research.

Sincerely yours,

Abraham G. Hartzema, Ph.D., M.S.P.H.
Assistant Professor
Pharmacy Administration

AGH:ch
Enclosure

[illegible] Abraham Gijsbert Hartzema

ABSTRACT OF RESEARCH PLAN

[illegible]

		DEPARTMENT AND ORGANIZATION:
Abraham G. Hartzema	Assistant Professor Clinical Assistant Professor	UNC-CH School of Pharmacy; UNC-CH Sch. of Public Health
Thomas R. Konrad	Research Assoc.; Asst. Prof.	UNC-CH Health Services Research Center; UNC-CH School of Public Health
June H. McDermott	Asst. Director, Pharmacy AHEC; Clinical Asst. Professor	UNC-CH School of Pharmacy
Fred M. Eckel	Professor	UNC-CH School of Pharmacy
to be named	Research Asst./Pharmacist	
to be named	Research Asst./Pharmacist	

ABSTRACT OF RESEARCH PLAN. State the [illegible] making reference to the health relatedness of the [illegible] briefly the methodology [illegible] DO NOT EXCEED THE SPACE PROVIDED.

The proposed project will examine a structured program of education, technical assistance to improve drug administration by staff of domiciliary care facilities (DCF's). The long-term objective is to prevent adverse or suboptimal drug therapy outcomes in the elderly residing in DCF's.

Significance: Domiciliary care is a growing phenomenon because of the increase in moderately impaired elderly, the diminished appeal of more costly alternatives. The institutionalized elderly are subject to specific risks from the inappropriate use of drug because of chronic and multiple health problems, physiological and psychological factors of aging and dependent and/or impaired status. Organizational factors in DCF's further contribute to difficulties in the administration and monitoring of drugs, misunderstanding and poor motivation by DCF staff and residents. Consequently, identification of effective interventions to reduce such risks seems an appropriate focus for research.

Specific Aims: The proposed research will initially examine the amount of variability in the universe of DCF's in terms of structure, organization of pharmaceutical services, and staff and resident characteristics affecting pharmaceutical services in DCF's. This information will be used: (1) to design suitable interventions for improving drug administration behavior; (2) to select a sample of DCF's which represents the major types; (3) to implement the intervention in selected DCF's; (4) to assess the generalizibility of findings to the entire population of DCF's; and (5) to disseminate the experience obtained to other DCF's through a "natural" network.

Methods: The methodology will vary according to the stages of the research project. A baseline survey of 120 DCF's will be conducted to identify barriers to quality drug administration. Sixteen DCF's will be selected for an indepth survey. Information obtained in the survey will be fed in an expert panel who will formulate educational objectives and develop strategies for adopting higher standards of drug administration in DCF's. Pharmacists will be used for the on-site introduction of drug administration techniques in 8 DCF's. The developed procedures will be disseminated to all DCF's by means of a newsletter. Adult Care Specialists and DCF Committees. The dissemination of the procedures will be a major element.

Hartzema, Abraham Gijsbert	533-78-1771

Specific Aims

The proposed project will examine several methods of improving the medication related behavior of staff and elderly residents of domiciliary care facilities (DCF's) through a structured program of education, technical assistance and systematic institutionalization of this innovation in the training of DCF staff.

The first aim will be to examine the amount of variability in the universe of DCF's in one state in terms of organizational goals, structure (both formal and informal), communication patterns, interorganizational linkages, staff characteristics and resident characteristics affecting pharmaceutical services in these facilities. This information will be used: (a) to design suitable interventions for improving medication administration behavior of staff and residents in different kinds of DCF's; (b) to select a sample of DCF's which represents the major types of these facilities; (c) to assess the generalizability of findings of these settings where the interventions are developed to the entire population of DCF's.

The second aim of the proposed research is to design interventions which are structured yet flexible efforts to:

promote more appropriate use of medications by residents; more appropriately motivated and informed medication administering behavior by the staff; more systematic monitoring and information feedback to prescribing physicians; and more adequate compliance with the standards established by the oversight agencies.

Such interventions will be characterized by the following elements:

- standard medication record keeping procedures and forms will be introduced.
- strategies and procedures especially suited for DCF's will be developed on-site to assure quality pharmaceutical services.
- Systematic and appropriately worded information about medications commonly prescribed or used (both Rx and OTC's), their indications, intended effects, side effects, interactions and methods of administration will be provided to DCF staff.
- Fostering communication between DCF staff, residents, prescribing physicians and dispensing pharmacists will be stressed so that DCF staff can act as more effective intermediaries in reinforcing appropriate medication taking behavior of the resident while at the same time enhancing the feedback that the resident may give to the prescribing physicians vis a vis his/her condition.

The third aim of this project will be to implement these interventions in 8 DCF settings in order to measure the impact of various components of the intervention on selected organizational, staff, resident, and community outcomes, and to test a selected number of hypotheses about the antecedents of successful implementation. Hypotheses tested are:

DCF managers receiving the intervention will show:

(1) improved attitudes;

(2) increased knowledge regarding drug administration;

(3) DCF's receiving the intervention will show a lower medication error rate.

The fourth aim will be the dissemination of the materials and procedures developed in this project. Communication between DCF's will be enhanced and the visibility of more developed programs will be encouraged through the development of formal recognition of successfully implemented programs and organized information diffusion through a newsletter and involvement of agencies, associations and committees at state and county level. Hypotheses tested are:

All DCF's surveyed will show:

(4) improved attitudes regarding drug administration;

(5) a greater concern for the drug therapy needs of their residents;

(6) an increased conformity with the standards.

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B. SIGNIFICANCE

B.1 Significance: Pharmaceutical Issues in Aging

The impact of recent and anticipated demographic changes on the health care requirements of the impaired elderly is one which is only now becoming apparent, but which will assume increasing economic and social importance for the remainder of this century and for the first few decades of the next century as well. Our elderly population faces a diminishing availability of informal family supports, an increasingly complex and costly health care delivery system, and greater vulnerability due to aging itself. Therefore special care must be taken to prevent adverse side effects of drugs. Kane, Kane and Arnold (1983), in a recent discussion of prevention and risk factors in the elderly, have advanced the notion that the elderly are characterized by a "narrow therapeutic window" which:

> in the arena of drugs, for example, [means] the range between dosage levels for benefits and side effects narrows for older patients.... (p.2)

The elderly are especially prone to therapeutic problems related to medication use. There are several reasons why the elderly are more likely than younger individuals to experience therapeutic problems. First, the aging process itself results in physiological changes which, in time, affect the absorption, distribution, and metabolism of medications (Hollister, 1981). As a result, the response of elderly patients to drug therapy is often unpredictable, and requires careful drug dosing, administration and monitoring.

Secondly, the elderly show a high prevalence of chronic illness and physical impairment (Vener, 1979). Consequently, the elderly consume a disproportionate quantity of prescription medications. While compromising 11 percent of the U.S. population, the elderly account for 25 percent of drug expenditures (Gibson, 1977). Recent studies estimate that among the ambulatory elderly aged 75 or older, approximately 87 percent take at least one prescribed medication (Law, 1976). When only the institutionalized elderly are considered, the figure rises to 95 percent. Further, the prevalence of polypharmacy is high among the elderly (Kaichthaler, 1977). Of those patients taking at least one prescribed medication, the elderly average 5 to 10 medications per day (Rabin, 1972). The concurrent consumption of several medications increases the probability of adverse drug reaction experiences and/or drug interactions. For example, many studies have demonstrated the high frequency of adverse effects of prescription drugs in the elderly (Lamy, 1981).

Certain of the drug side effects commonly experienced by the elderly, such as sedation, orthostatic hypotension and gastrointestinal disturbances, are particularly significant. Sedatives and orthostatic hypotension may cause falls which can result in fractures, strokes, and attacks. Gastro-intestinal side effects, such as appetite depression, nausea, and stomach irritation, can be particularly important in the elderly whose nutritional status may already be compromised. In addition, medications can exacerbate or produce a variety of disease states in the elderly, such as glaucoma (Godwin-Austen, 1971), cholestatic jaundice (Holloway, 1974), hyperkalemia (Meier, 1983), and tardive dyskinesia (Jenike, 1983). Review of the drug regimen at regular intervals can prevent these problems inherent to drug therapy in the elderly.

Thirdly, the elderly experience a high incidence of medication errors. Estimates of the incidence of medication errors in the elderly range from 25% to 50% (Parkin, 1976; Schwartz, 1962). While, estimates of the rate of medication errors in long term care facilities range from 0 to 59 percent (Morse, 1982).

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Administration of medications is a major source of errors. Trained personnel such as licensed nurses, nursing aides or medication technicians are responsible for medication administration in nursing homes. However, errors are probably compounded in DCF's where untrained personnel are in charge of medication administration. Since a large proportion of DCF personnel are elderly themselves, may have limited formal education, no medical background and poor motivation, errors in medication administration are likely to occur.

Disentangling how much of the risk that the elderly have for adverse health outcomes is due to various factors is no easy enterprise. It is clear, however, that identifying high risk groups of the elderly is somewhat easier. These tend to be persons who are very old, over 75 years, lacking social resources (i.e., with no spouse, kin or informal social supports), and those who have few material resources (e.g., money, income, assets). Clearly social and physiological factors are both involved in producing adverse effects.

B.2 Significance: Structure of Domiciliary Care Facilities

In the proposed demonstration we will attempt to identify and modify risk factors, and reduce adverse health outcomes for a high risk group of the elderly. These are institutionalized in "board and care" or "domiciliary care" facilities (Palmer, 1983). As Scanlon and Sulvetta (1983) have observed:

> No standard nomenclature exists for these facilities and they are variably referred to as domiciliary care facilities (DCF's), congregate care facilities, board and care homes, community care homes, family care homes, adult foster care, homes for the aged, homes for adults, group homes, rest homes, residential care, sheltered care, homes for the developmentally disabled, and community living homes. However, they do generally conform to a common purpose, which is to provide room, board and protective oversight to residents. Protective oversight involves such functions as providing required assistance with personal care, supervision of resident activities, monitoring of special diets, central storing and distribution of medication, assistance in taking medication, assistance with acquiring medical and dental care, and supervision of residents' money or property. Protective oversight specifically excludes "nursing care" (emphasis added). (p. 44)

Other analysts have observed that the future of such facilities as the location for long term care is likely to increase (Feder, 1983; Stone, 1983). This is due, not only to the high cost of nursing home care borne by state governments, but also due to the fact that states can shift this cost of care to the federal government by placing persons in domiciliary care and putting them on 100 percent federal SSI payments. More recently, policy analysts have speculated that the altered Medicare reimbursement procedures for hospitals ("DRG's") will lead to discharge patterns that will increase the demand for all forms of long term care including DCF's.

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Although the demand for care is likely to increase, it is not apparent that this demand will be translated into an increased supply of "health care" type facilities. States still learning from the rapid increase of nursing homes in the 1960's and 1970's will instead attempt to promote "low technology" options like "board and care" or "family home" facilities (Oltman, 1981). In a recent report prepared for DHEW (Dittmar, et al., 1983), the authors conclude after an intensive survey of ten states that:

> The need for additional supervised community residential facilities for....he elderly is evident from the data. (p. 1)

National studies of such facilities have identified the quality of care as problematic both because of a lack of adequate definition of quality and the lack of mechanisms to encourage and/or enforce standards. The first quality of care issue identified by the largest recent nationwide study of domiciliary care (Stone, Newcomer and Saunders, 1982) has identified:

> ..misadministration of medication as a major area of non-compliance among board and care operators. To ameliorate this situation, regulatory changes have been suggested which would increase the operator's responsibility from supervision to direct administration of medication. (p. 24)

This report goes on to identify questions that need to be answered as a result of the suggested policy change.

- What would be the consequences of such a change for the provider and resident?
- In particular, how would this affect staffing and training requirements?
- How would such changes impact on other levels of long term care?
- How would such changes affect administrative and program costs?

Community based residential care for the impaired elderly is also increasingly attracting the attention of researchers interested in the potential and limitations of such environments (Bradshaw, 1976; Falloon, 1983; Rothwell, 1983). As Bradshaw and her colleagues note, "Foster home care for the aged can furnish many advantages if the resident is properly placed and support services are provided". Improved techniques of drug administration and enhanced knowledge and attitudes of administrators of DCF's are clearly one of the key support services required to reduce risks for the elderly residents.

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C. EXPERIMENTAL DESIGN AND METHODS

C.1 DCF's Drug Administration Standards in N.C.

North Carolina's supply of domiciliary care facilities (DCF) include 324 homes for the aged and disabled (HAD) housing over 12,000 individuals and 630 family care homes (FCH) housing nearly 3,000 individuals. The difference between the latter and the former facilities is characteristically one of size, with the FCH limited to housing 6 or fewer residents. (See Appendix A for a mailing list of DCF's in North Carolina.) Revision of current N.C. standards for DCF's is finalized and will become effective April 1, 1984. Two separate sets of standards are developed: "Minimum Standards and Regulations for Family Care Homes" and "Minimum Standards and Regulations for Homes For The Aged And Disabled". (See Appendix B and C for the standards concerning pharmaceutical services in FCH and HAD.)

These standards describe regulations concerning prescription drugs and over-the-counter drugs, labeling of the drugs, and include extensive regulations for the storage requirements of the medications, stop orders, administration of medications and maintenance of medication records. Most important, the standards put the DCF managers in charge of the medication administration except if the physician provides a written order that the resident self is in charge of drug taking. Also, OTC medications can only used by residents if prescribed by a physician. These last two regulations in the standards transfer the responsibility of drug administration largely from the resident to the manager of the facility. The role of the manager in drug administration becomes an important one, underlining the need for an educational and technical intervention program especially targeted at DCF managers and staff.

The standards for the Family Care Homes and the Homes for the Aged and Disabled differ in two minor points. The standards for the Homes of the Aged and the Disabled require, under Section IV.C.6.e (1), special sanitary provisions for washing hands and, under point 4, locked storage space for drug carts if used in the facility. These two standards are not included in the standards set for Family Care Homes. Except for these two regulations the standards are virtual the same.

Facilities licensed before April 1, 1984 will have until April 1 1985 to comply with certain new administrative and programmatic requirements of these standards. For both FHA and HAD applicable rules are Section V.C.4.h and V.C.5 concerning medication administration and drug therapy review.

> Section V.C.4.h: Oral solid drugs must be prepared for administration within 24 hours of the prescribed time for administration. The administrator must designate appropriately trained staff to be responsible for preparing the drugs for administration.
>
> Section V.C.5: The administrator is responsible for obtaining a drug regimen review of each resident at least every six months. This is to be performed by a pharmacist, physician, public health nurse, or the registered nurse. The administrator must assure that he/she is informed of the results of the review. The form DSS-1867 or the equivalent is to be maintained by the facility to record these findings, recommendations and

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corrective action.

These two standards become in effect April 1, 1985, directly before the survey. on-site observation and interviews are planned. Providing a timely opportunity for an demonstration project. (See Appendix D for a copy of form DSS-1867.)

The new N.C. standards for DCF's parallel for pharmaceutical services regulations, the standards set for Skilled Nursing Home facilities. The standards for nursing homes, however, developed in an evolutionary process taking 20 years. (Long Term Care Facilities Improvement Study, 1975). While the literature contains many studies addressing drug distribution and administration problems in nursing homes, the literature on drug administration studies in DCF's is relatively scanty. Since domiciliary care facilities take care of a larger proportion of the population than nursing homes do, show simular drug use pattern (Frenier, 1978), but have organizational features quite different from nursing homes and show major deficiencies in correct drug administration, a research effort to prevent suboptimal and adverse drug therapy outcomes in DCF residents directed at managers and staff seems to be justified.

C.2 Adherence to Drug Administration Standards in N.C. DCF's

Eckel (1971) surveyed 68 of the 125 HAD in North Carolina having 25 or more residents. Only few of these larger DCF's were found to maintain medication records, 33% did not have a dedicated drug storage place and in an equal number of facilities expired drugs were found. In 81% an aid or nurse handled medications, in the other 19% the manager was responsible for medication administration. In 89% of the DCF's the employees had only on-the-job training. The managers showed a low awareness for medication administration problems. 72% perceived no problems with medication administration and only 12% thought that any improvement could be made. Commenting on the significance of the problems identified, Eckel remarks:

> The lack of untrained health professionals employed by resthomes makes the solution to these problems difficult.....Pharmacist conducted in-service education to the personnel of the home could well supplement the on-the-job training received by most employees. A pharmacist can teach proper drug control and proper times and methods of drug administration.

The Group Care Facilities Branch of the Division of Facilities Services, Department of Human Resources, State of North Carolina conducted a "Medication Control Survey" in 1982. A total of 30 facilities across the state were surveyed. The summary report states:

> Based on the percentage which indicated a deficiency, and on the seriousness of the problem, the following areas are ones which need the most improvement:

1. All the statements pertaining to "Labeling of Drugs".
2. External use medications mixed with oral use medications.
3. No control and accountability of controlled substances.
4. Staff indicates too many medications are being used or overmedication.

37-680 807

PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR OR AWARD CANDIDATE (Last, First, Middle)	SOCIAL SECURITY NUMBER
Hartzema, Abraham Gijsbert	533-78-1771

5. No vital signs to support drug therapy.
6. R.Ph. does not repackage for temporary leave--e.g. envelopes.
7. Medication cards do not identify drug--has only patient name.
8. Family, guest, residents bring in their own over-the-counter drugs.

The magnitude of the medication error problem in DCF's can further be illustrated with the following findings as cited from the report: in 40% of the facilities, directions for use were not parallel with current physician order. In 18% of the facilities, medications were stored in the bathroom. In 17% of the facilities, refrigerated medications were stored with food and accessible to unauthorized persons. Medication records did not identify drugs and showed only patient names in 86% of the facilities. Forty-seven percent of the facilities showed patients with unauthorized over-the-counter drugs. Medication administration appears to be a significant problem in these facilities. The 30 responding DCF's are only a small fraction of those contacted initially. Consequently, the drug administration problem identified may actually represent an underestimate of the true magnitude of the problem. To the extent that any generalizations can be made about DCF's, the North Carolina experience with this category of facilities is typical of most states.

As illustrated the "Medication Control Survey", the standards are not met in many DCF's. This may be in part due to the different roles of state and local agencies in developing, implementing and reinforcing standards. Although both are within the department of the N.C. Department of Human Resources, the Division of Social Services has the primary responsibility for developing the licensure standards while the Division of Facility Services has the primary responsibility for reinforcing the standards through licensing procedures. In the field the primary responsibility for routine monitoring of the standards is by the Adult Homes Specialist stationed by each County Department of Social Services. A secondary effect of the project will be an increased communication between the different agencies involved in domiciliary care. (See Appendix E for a role definition of the agencies and committees involved in DCF's.)

An recent effort to improve drug administration in DCF's was a conjoint program of the Area Health Education Centers and the North Carolina Association of Long Term Care Facilities, undertaken in 1983. This continuing education (C.E.) program proved not to be successful. Poor motivation among the DCF managers resulted in low attendance rates, while course evaluations showed a weak understanding of the concepts presented. An explanation may be that curriculum development was based on nursing home experiences of the presenting faculty members. (See Appendix F for an outline of this C.E. curriculum.) Attaining quality of pharmaceutical services in the domiciliary care industry in a relatively short time span requires an intervention including individual teaching, technical support and follow-up.

C.3 Implications of the N.C. Sample for Research and Policy Formation.

The proposed intervention will account for the different resources available in the domiciliary care industry as compared with the nursing home industry. Implementing technical procedures in DCF's that are costly and contribute marginal to patient outcomes but resemble nursing home procedures are not cost effective. The technical, financial and managerial resources available in DCF's should be explored first to accomplish an optimal fit of the new standards within routine DCF's practice procedures. This approach will greatly facilitate the adoption of the standards in the

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domiciliary care industry throughout the state. North Carolina is a state which resembles many others in its use of DCF's within the spectrum of long term care resources, and has a range of regulatory and enforcement policies consistent with the experience of other states.

C.4 Survey Methodology

The first step in achieving the goal of this study, to foster rational drug use in domiciliary care centers, will be a careful and objective assessment of the current status of pharmaceutical services in domiciliary care centers. Data will be collected to identify needs for improvements in pharmaceutical services with reference to established standards; to develop innovative programs to meet those needs; and to measure the overall impact of the interventions undertaken. The baseline data will be collected by means of a survey and supplemented by indepth interviews of a subsample of the managers and residents of domiciliary care facilities and on-site observation of actual pharmaceutical services delivery.

The proposed methodology calls for a survey of the 954 licensed FHC and HAD facilities in the State of North Carolina. The managers of 120 random selected facilities will be surveyed. The survey will probe the managers' response to solicit actual and perceived barriers in implementing the new standards. Attitudes toward pharmaceutical services will be measured and estimates of personnel, time and financial resources committed to pharmaceutical services will be obtained. Managers expectations that they can affect meaningful and positively the health outcomes of residents cared for, will be measured with the "Parent Health Locus of Control" scale. (DeVellis, 1984). Selected subscales from the Multiphasic Environmental Assessment Procedure (Moos and Lemke, 1979) will be included in the survey instrument to asses the physical environment and organizational structure in which the drug administration takes place.

Adult Care Specialists will be asked to administer the survey on their monthly routine visits to the DCF's. These personnel are present in each of N.C.'s 100 counties. A training session will be organized at three AHEC sites throughout the state for training the Adult Care Specialists in proper questionnaire administration. The survey will be adminstered twice, once before the intervention to obtain the baseline data and in a shortened version at the end of the study period. Approximately 30 Adult Care Specialist will be involved in this phase of the project. This approach will assure a high rate of response.

The study will also employ a two stage stratified sampling procedure. In the first stage, the homes will be stratified in three groups by size: those with 6 or fewer residents; those with 7 to 25 residents; and those with more than 25 residents. Six facilities from the <6 stratum will be randomly selected, four in the stratum 7-25 residents and four facilities from the 25> stratum. Three of the facilities from the <6, two in the 7 to 25 residents stratum and two in the 26> stratum will be considered the control group. The pharmaceutical services in all sixteen facilities will be examined and observations will be made of medication administration processes by pharmacists. This first on site visit is intended to collect baseline data on medication error rates. For this study, an adapted version of Barker's disguised observation technique for drug medication errors will be used (Morse, 1982). Barker's technique allows for the identification of the causes of the observed medication errors and for quantification of this type of errors.

In the second stage of the sampling procedure all residents of the <6 category, and six

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randomly selected residents of each, the 7-25 and 25> residents category of DCF's will be interviewed indepth. A medication history will be taken and a review of education use will be made. The interview will employ a structured questionnaire.

Based on the survey, observations and interviews, priority problem areas will be identified amenable to solution through education of the domiciliary care managers and staff. The educational intervention must be adapted to the educational level and other socio-demographic characteristics of the manager. Previous research suggests this to be important. For example, Sherwood (1983) found in the Pennsylvania domiciliary care experiment that the majority of the managers had graduated from high school, 30% were black, 50% were single (predominantly female and widowed), and the average age of the managers in this study was found to be 56. Similar patterns were observed by Bradshaw and her colleagues (1976) seven years earlier in Louisville, KY. It was further reported that 20% of the managers or providers reported spending less than four hours per day caring for the residents. Forty-one percent spent between four and eight hours each day, and 38 percent reported spending more than eight hours each day. The level of requirements for the pharmaceutical service component in domiciliary care facilities should be based on the intellectual and physical capabilities of the managers and with due regard to reasonable time commitments and financial resources.

An expert panel will be assembled for the interpretation and synthesis of the first phase findings. The task group will include representatives of the N.C. Division of Social Services, N.C. Division of Long Term Care Facilities, N.C. Department of Human Resources, the Adult Care Specialists of the counties in which the DCF's are located, Area Health Education Center (AHEC) pharmacist, representation of N.C. Association of Consulting Pharmacists, project consultants and the investigators. The expert panel will meet prior to the planned intervention and during the follow-up phase.

This expert panel of interested parties and consultants will interpret the information obtained in the survey, observations and interviews, develop educational objectives and goals for the intervention, identify techniques for the implementation of the standards based on the organizational structure of the DCF's and economical resources available, and suggest solutions for problems identified during the follow-up. Evaluation of the the educational materials prepared for the intervention will be another of the task group's assignments. In addition, the expert panel will be asked to propose alternative, innovative and effective strategies for the dissemination of the demonstration's results within the state and at the national level. It is estimated that the panel will meet four times during the project.

C.5 Intervention

The proposed survey, observations and interviews are intended to provide the basis for an intervention developed by the expert panel to be used in the demonstration project. The demonstration project itself will involve an in-service training program by pharmacists for DCF managers and on site assistance to bring the facility on a par with the standards based on the resources available. The intervention will be implemented in the eight experimental facilities selected in the first phase of the project.

Four components can be identified in the intervention. These include: 1) the use of pharmacists to bring the medication profiles on an acceptable level congruent with defined standards of practice and to introduce proper drug administration techniques; 2) an educational program for managers raising the manager's awareness of the importance of the medication profile in drug administration and thus resident care; 3)

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skill development to make effective use of the medication records; and 4) increased motivation for continuing support for these activities. In addition, general awareness of a variety of health care matters will be raised among managers of domiciliary care facilities.

C.5.1 Implementation: Process

The main thrust of the intervention will be an in-service training program conducted by pharmacist/students. In this demonstration project, pharmacists will visit the eight experimental DCF's. At the site, DCF managers or other personnel in charge of medication administration will participate in a program intended to improve drug use in these facilities. Three on-site visits, in addition to the one visit for baseline data collection on medication errors, are scheduled. The first on-site visit will include the training session and assistance in implementing practical solutions to adherence in a cost/effective manner to the standards. A follow-up visit will be scheduled one month later to reinforce good practices and rectify problems that might have arisen in the day-to-day adherence to the standards. A third visit three months later will have the same function. From here, continuing education programs should provide the manager and staff with the information and skills to provide quality pharmaceutical services.

At the first on-site visit the prescription drug labels and records of all residents will be reviewed for accuracy and completeness. If a prescription is not clear or the dose seems to be unusual, it will be clarified with the prescriber or the dispenser before it is transcribed on the medication record in the medical information log. Non-prescribed remedies and previously issued prescription medications found in the residents' possession will be identified and recorded for future reference. In addition to taking the complete medication history of all residents, the prescriptions will be checked for interactions or adverse reactions and drug allergies will be recorded. The patient medication record will contain the drug name, frequency of dosing, mode of administration and cautions concerning special side-effects, drug allergies, and non-prescription remedies which are contraindicated.

The medication record and prescription label are controls in the correct administration of medications. The prescription label is the single most important documentation in the process of administering drugs. It should contain all information required for the correct administration of the medication. The managers need to learn to recognize this information and abstract correctly the information from the label in the medication record. Medications of all the residents are to be recorded on individual records collected in the medical information log.

The main purpose of this educational strategy is to teach the manager to use the medication records in the most effective way. The second purpose is to document problems experienced by managers and staff for reference in the dissemination of information to other DSF's. The third purpose is to gain acceptance of the medication record as an ongoing part of resident care. This reinforces the importance of providing for the patient at every physician visit an updated copy of the medication record, as well as emphasizes the importance of letting the physician complete the record each time the drug therapy of the resident is altered.

Further, customary drug administration processes will be implemented and practical solutions to improve care will be explored in cooperation with the DCF manager. These solutions will be based on the strategies for improving drug administration in DCF's developed by the task group and existing literature. (See Appendix G) A rationale for

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the strategies used will be given, questions will be encouraged, and procedures will be clarified. As secondary effect of the intervention, the eight DCF's will be in close conformity with the new standards. Information derived from the experience in these eight "model" facilities will be fed in the "natural" network of agencies, organizations and committees involved in DCF's.

C.5.2 Implementation: Products

A special medical information logbook will be prepared for the managers of the domiciliary care centers. Its main purpose will be to store and organize the medication records and patient health histories. The logbook is also intended to provide information concerning the administration of medications and will serve as a resource guide for all personnel handling drugs in DCF's, especially those who are directly involved in resident care. An eductional intervention will accompany the introduction of the medical information logbook to the managers. Bound with the logbook will be a manual containing:

- a section with medication administration techniques and information;
- information on the 40 most commonly used drugs by the elderly in these institutions;
- information on the the most common illnesses that can be treated with OTC products;
- a section with general health information, such as foot care in the elderly, dental care, vision care, etc., and
- a medical glossary with terms used by physicians and pharmacists.

The medical information logbook will have the format of a looseleaf binder. The first section of the logbook will contain the medication records of each resident. A medication record form will be designed specifically suited for the skill and educational level of the DCF managers. The lefthand page will contain the medical history and other pertinent information while the righthand page will contain a medication administration record. NRC carbonless paper will be used for the medication record so that the manager can provide the patient's physician with a copy of the patients' medication history upon every visit. These copies can also serve in the six month medication record review as mandated by the new standards.

In the second section, information will be provided on the 40 most frequently prescribed drugs as found in the DCF's. This information will be taken from the UPS DI patient information and adapted to the educational level of the managers. Drug information will be screened for esoteric pharmaceutical or medical terminology. Terminology not known by the managers or their staff will be included in the medical terminology glossary. The function of this section is to provide the manager with background information on the drugs. The manager can communicate this information to the patient, since the manager (rather than the patient) often obtains the medications at the pharmacy. The manager must not only understand the drug information, but must also be able to explain the medication information to the resident under his/her supervision.

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C.5.3 Implementation: Dissemination

The dissemination of the resulting techniques, advise and educational materials will be based on the "natural" network resources available in the state North Caralina. Network ties will be strenghtened to carry the information effectively. Important elements in this network are the N.C. Division of Aging and its commitment to distribution of information, the Adult Care Specialists which are in day-to-day contact with the HAD and FCH, and the Domiciliary Home Community Advisory Committees which are a community resource in quality assurance of the DCF's. In the dissemination phase of the project, these "natural" network resources will be extensively utilized.

A newsletter will be prepared and sent to all the managers of the DCF's quarterly during the intervention and evaluation phase. The mailing list will also include the Adult Care Specialists and the Domiciliary Home Community Advisory Committees members. This newsletter will be produced in cooperation with the N.C. Division of Aging. The Division of Aging supports the licensure and regulation of DCF's. An major role of this agency is "providing information about issues important to the care of ag[illegible] persons in domiciliary homes".

The purpose of the newsletter is to provide support for a continuing effort in maintaining the medication profiles; provide information on drug use in the elderly; information about the storage and administration of drugs; and information on self-medication. The priority of the topics covered will be determined using the baseline data and reports of the pharmacist/interveners on the problems encountered by the on-site visits. The newsletter can also serve to enhance the visibility of the demonstration sites and to disseminate the medication information logbook as a product to be adopted by other DCF's.

An important role will also be played by the Domiciliary Home Community Advisory Committee. The function of these committees is defined by the N.C. General Statute 131D-31 and amended in March, 1983. According to this statute, each county with one or more licensed FCH or HAD is required to have such a committee. The committee is composed of at least five members which serve voluntary. One third of the members are nominated by Domiciliary Care manager. Financial interests in HAD and FCH, employees or family members are not eligible for Committee membership. The final responsibility for the initiation, composition and continuation of these committees lies by the Division of Aging.

These committees, as overviewers of the quality of care in HAD and FCH from a community perspective, will be involved in the dissemination of information. After the task force has made its recommendations, an educational session will be scheduled in all seven AHEC's through the state for the 500 committee members. In addition all 100 Adult Care Specialists will be invited to attend this conference. The purpose of the session will be to introduce the project, discuss the importance of correct drug administration in the elderly, outline strategies for improving drug administration in HAD and FCH and demonstrate the medication information logbook and other materials. The three objectives here are: (1) to raise the awareness of committee members of drug related problems in the elderly, (2) to demonstrate the prevention of drug related problems in DCF's, and (3) to initiate a discussion at the county level about pharmaceutical care in HAD and FCH facilities. (See Appendix H for a definition of the role of these agencies as outlined in the Minimum Standards.) (For a description of the AHEC's, see Appendix I.)

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An important mechanism for ensuring quality and upgrading standards is the voluntary oversight program in North Carolina. North Carolina's Association of Long Term Care Facilities has, over the past six years, assumed an increasingly active role in monitoring DCF's and promoting quality of care. This organization has also conducted substantial lobbying efforts in the state legislature to encourage an increase in state SSI supplementation. The Association provides a continuing education program which is mandatory for all potential members. A recent continuing education program directed at problems in pharmaceutical services, as discussed before, was not succcesful. However, the Association has committed itself to provide its members in the future at regular time intervals with a drug administration continuing education program based on the materials and experience obtained in this study; as such, providing for continuity in the dissemination of the study findings.

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C.6 Evaluation

C6.1 Evaluation Focus and Instrumentation

A systematic evaluation of the intervention requires a multi-faceted approach. As such, the evaluation process should encompass each phase of the intervention, such as implementation process, product outcome, dissemination, and institutionalization; each objective intended of the intervention strategy: increased knowledge, more positive attitudes, improved medication administration practices and reduced medication error rates; and each group affected: the policy makers/regulators, agencies and organizations, DCF administrators, and DCF residents. This three-dimensional model is useful in reflecting the complexity of the evaluation effort, and the nature of the relationship between the various targets, phases, and objectives. See Figure 1.

In the initial baseline survey in the random selected 120 DCF settings, the evaluation process will concentrate on the development and validation of simple and concrete indicators of knowledge, attitudes, organizational structure and practices related to drug administration which can be deployed in evaluating the dissemination and adoptation of the program among all DCF's in N.C. Because drug administration problems in DCF's have not been studied in any systematic manner previously, much of the indicator and instrument development and validation will be guided by previous efforts in ICF's, SNF's, and in community based programs of health promotion for the elderly. (Shammansky and Hamilton, 1979)

Evaluation of the implementation process will focus on each of the components identified above:

(1) Quality of Resident Care: Systematic comparisons of the pre and post behavior of DCF administrators will be made. The frequency of certain drug administration practices is expected to change. More frequent complete and up-to-date medication records should be observed, while less frequent underdosing, overdosing or unauthorized use of OTC products should be found. Medication error rates will be reduced, however, more so in the eight study facilities than in the control group.

(2) Increased awareness of the importance of drugs in residents' health maintenance by the managers will be measured by pre and post knowledge and attitudes. An instrument building on the conceptual work of Walston, Walston, and DeVelis on "Parent Health Locus of Control" will be included in the survey. This instrument is developed to be administered to parents of children with chronic diseases. (DeVellis, 1984) It is hypothesized that exposure to the intervention will increase managers' knowledge of drug administration and expectations that they can affect more meaningfully and positively the health outcomes of residents under their care.

(3) This increased awareness and motivation is expected to entail a role change of the manager as an intermediary between the health care professionals and the DCF resident. This enhanced role implies that: 1) the DCF manager and staff will serve to explain and interpret for patients instructions and directions given to the manager by health

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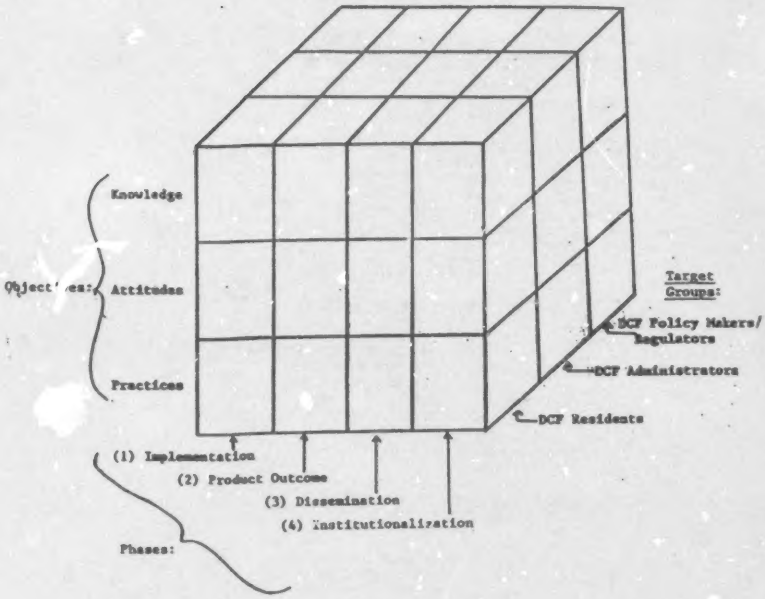
FIGURE 1



EVALUATION MATRIX

Phases, objectives and target groups involved in the evaluation of the drug administration in DCF's projec..

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care providers more effectively and appropriately; and 2) that the manager will develop advocacy and articulation skills in order to bring before the physician and pharmacist a clearer picture of the patient's subjective states and symptoms. Pre-post measures of attitude change associated with acceptance of this intermediary role will be developed using questionnaire data, validated by direct observation in the DCF's of the pre and post test frequency with which managers can identify a health care professional, such as a physician, pharmacist or nurse which provides assistance in the mandatory half yearly drug use review.

Evaluation of the demonstration products will be done via questionnaires and interviews. The focus of this evaluation phase will be on the product characteristics, rather than exclusively on the content. Such characteristics include such factors as readability, convenience, clarity, and ease of integration into DCF routines. While these characteristics are most important to DCF operators, the use of the medication information logbook as a monitoring and/or teaching tool will be stressed for the DCF regulators and policy makers, especially Adult Care Specialists and consultants involved in examining the DCF day-to-day operation. Their evaluation of the product characteristics will be ongoing and fed back to improve these characteristics.

The third phase of dissemination will be assessed in three ways: (1) the extent of acceptance of the program (and specific program components) by all DCF administrators in the state of North Carolina will be measured behaviorally by frequency of requests they initiate for technical assistance in this area and the number of products they request from the agencies and associations which are distributing them; (2) the knowledge and attitudes of the DCF administrators will be measured by the pre/post differences on selected items in the statewide survey of a sample of 120 DCF administrators; (3) the relationship between dissemination activities and knowledge and attitude change can be examined by means of correlations between (1) and (2) above.

The fourth phase of institutionalization is measured by (1) the extent to which state and local DCF technical assistance, advisory and educational personnel make use of the products and processes developed in the demonstration, (2) these agents' expressed assessment of its utility in helping them achieve their mission of regulation, assistance, and/or education; and (3) the willingness of these agencies to underwrite the ongoing support of the distribution of the products and implementation of the technical assistance. The number of contacts and rate of use of the products will be recorded over the life of the project, and brief structured assessments of product and process utility--using instruments that complement those developed for DCF administrators--will be done with policy makers/regulators.

C.8.2 Evaluation Design: Implementation Phase

The design of the evaluation will rely upon an experimental approach in which the eight DCF's selected for intervention will be paired with eight others selected as comparison facilities. Data collection will proceed in the comparison facilities at the same time as in the eight demonstration sites. Although precautions will be taken to prevent contamination of the intervention to the comparison facilities, these latter will not be precluded from becoming involved in the intervention in the dissemination phase of the pro-

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C.6.3 Evaluation Design: Product Design Phase

Each constituency using the products (i.e. the DCF administrators, Adult Care Specialists, and technical advisory panel) will be asked to rate each component of the medication administration log and accompanying handbook along a series of dimensions using Likert-type scales. Among these are readability, comprehensiveness, ease of use, amount of time involved in use, and the extent to which errors in recording can be avoided. Standard syllable count measures of readability will also be used. Successful product characteristics will be identified where there are favorable evaluations across all three groups of users.

C.6.4 Evaluation Design: Dissemination Phase

The dissemination phase will be assessed through descriptive time series techniques. The cumulative frequency of adopters of the innovation will be recorded and the characteristics of the DCF's with high and low rates of implementation will be assessed. Because exposure times may differ due to different levels of geographic proximity to AHEC training interventions, careful monitoring of attendance at each of these sessions by DCF staff is essential.

Data collected in the initial survey of DCF's will be used to discriminate between those who implement the program (i.e., ask for the medication information logbook and manual) and those who do not implement. Multivariate techniques of logistic regression will be used to isolate these predictors.

C.6.5 Evaluation Design: Institutionalization Phase

During this phase the extent to which the demonstration program is adopted by the trade association, the Adult Care Specialists in the County Departments of Social Services, and the local Domiciliary Home Community Advisory Committees will be monitored using background and profile data collected from these participants during the course of their "product evaluation". Multivariate techniques of logistic regression will be used to isolate these predictors.

C.7 Statistical Analyses

In general the types of analyses which will be utilized in the evaluation have been indicated in the evaluation section above. Details of the statistical analyses employed in the evaluation of the implementation phase and the dissemination phase are provided here.

C.7.1 Statistical Analyses: Dissemination Phase

As described previously, the knowledge and attitudes of the DCF managers will be measured by the pre/post differences on selected instruments in the pre and post survey of 120 DCF managers.

The design of this phase is illustrated in the following schematic:

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Post-Dissemination Questionnaire

Pre-Dissemination Questionnaire	Response	Non Response	
Response	RR		R1
Non-Response			
	R2		

Where pretest and posttest measurements can be made only for the group which responds to both questionnaires (RR). Separate comparisons of the marginal response categories (R1 and R2) to determine the presence of non-responder bias will be made.

The instrument used to measure managers' attitudes toward pharmaceutical services, activity levels, organizational structure and physical environment will incorporate subscales from the Multiphasic Environmental Assessment Procedure (Moos and Lemke, 1979) and will contain questions with ordinal responses.

The analysis will involve the computation of a composite score for a series of questions related to a certain dimension. Several such dimensions will be identified. Thus, the categorical responses obtained can be analyzed employing statistical tests for continuous variables since the composite scores which will be continuous. Statistical tests used to measure the effect of dissemination include:

1) Paired t-tests of mean differences in composite scores.
2) Mc Nemar's test to assess proportions who change attitudes or behaviors.

An example of the lay-out for this test is shown below:

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Post-Dissemination

Pre-Dissemination	Adherence	Non Adherence
Adherence		
Non-Adherence		

Where the responses adherence and non-adherence refer to a particular standard. Significant differences in the positive direction in the diagonal elements of the table will indicate a significant effect of the dissemination.

Statistical Analyses: Implementation Phase

Eight facilities to receive the intervention will be randomly selected from three strata of the overall population of DCF's which are categorized by size: 0-6 residents, 7-25 residents, and >25 residents. Four homes will be selected for stratum 1 and two homes each, for strata 2 and 3. Eight control facilities will be paired with these intervention facilities. Pre and Post intervention measures will be made according to the following design for each stratum:

Measure

Group	Baseline	1-month Follow-up	3-month Follow-up
Intervention			
Control			

The instruments used for the baseline and follow-up of the intervention measures include attitude surveys and measures of medication administration error rates.

The analyses of these data will include:

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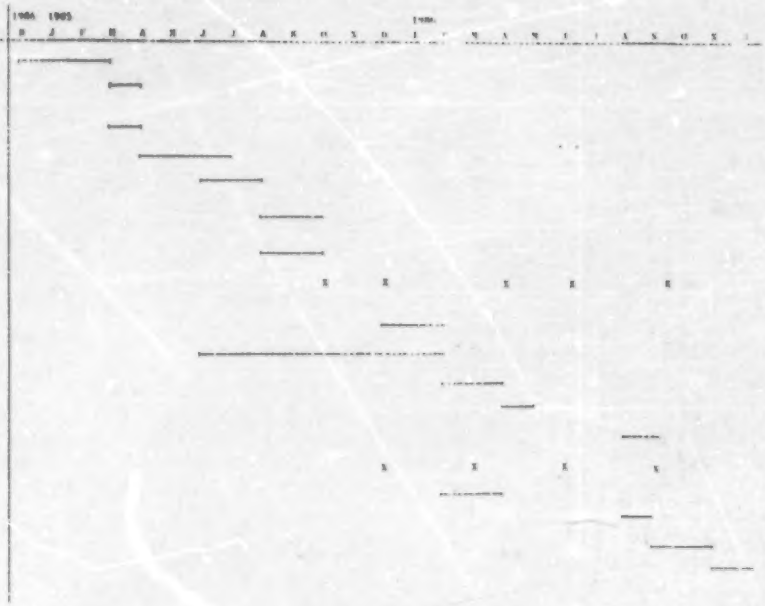
1) Chi-Square tests of independence of the groups with respect to the categories of response for discrete variables for the baseline and follow-up measures.
2) Weighted Least Squares analyses of groups for categories of response for discrete variables for the pre and post measures simultaneously. Interaction tests here would indicate a treatment effect.
3) Weighted Least Squares techniques for discrete variables and two-way analyses of variance for continuous variables for tests of trends over strata, where the factors are group and strata, performed for baseline and follow-up measures separately.
4) Two-way analyses of variance for continous variables to ascertain the effects of the dissemination process (control group), the intervention process (experimental group) and their interaction over the strata. Change scores (differences between follow-up measures and baseline measures) will be computed and used as the dependent variables in these analyses. The factors will be group and strata.



Abraham Gilgebert Bartsema

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APR 02 1984

March 30, 1984

The Honorable Ike F. Andrews
Chairman, Subcommittee on Human
Resources
Committee on Education and Labor
U.S. House of Representatives
2201 Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Andrews:

This is to express support for your proposed amendment (H.R. 4472) to the Older Americans Act to include "Older Americans Personal Welfare Education and Training Program". An education and training program as you propose would be most beneficial to the elderly, and one given through the multipurpose centers would be one of the most effective ways of reaching the elderly. Currently, efforts to obtain information about health care problems or to find educational programs about health care are difficult and time consuming as well as generally being costly. Broad spectrum programs in multipurpose senior centers would make education and information available to the elderly with their peers in an easily accessible location and in a non-stressful situation.

We do suggest, however, that the amendment be modified to ensure that diminished eyesight and vision loss are looked upon as major "health" problems encountered by the elderly. Too often the loss of vision is not recognized as a health problem.

Education and training in vision care and in the use of aids and devices to permit the most effective use of residual sight and where low vision services are available are some of the more effective ways of permitting those with vision problems to remain as active members of the community. We suggest that Section 704(b)(1)(D) be modified to include "loss of or diminished vision", and that

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37-080 O—84——25

The Hon. Ike F. Andrews
Page Two
March 30, 1984

704(b)(1)(E) be rewritten to read "will provide education in the safe and effective use of prescription and non-prescription medicines and training in the use of aids and services to overcome or minimize the effects of handicaps in vision, speaking, hearing and use of limbs.

I am attaching for your use and information data which show, among other things, that almost 25% of the elderly population suffer from some sort of visual impairment but that an estimated 50% of all geriatric blindness is preventable with proper preventive care and regular medical eye examinations.

We appreciate your efforts to make the programs funded under the Older Americans Act viable service providers for the elderly and to expand the act through "title VII" which will be beneficial to the elderly and to society as a whole.

I would appreciate your making this letter part of the record of hearing held by the Subcommittee on Human Resources on H.R. 4472 on March 28, 1984.

Sincerely,

Glenn M. Plunkett

Glenn M. Plunkett
Specialist in Governmental
Relations

Attachment: Data on Aging and Vision

FACTS ON AGING, BLINDNESS AND VISUAL IMPAIRMENT

FACT: According to the National Society for the Prevention of Blindness in 1978 there was an estimated 498,000 legally blind persons, of whom 53% or 269,950 people were elderly. Over 55% of all new cases of L.B. are individuals 65 and over. The projected number of legally blind older persons by the year 2000 will increase to an estimated 367,000.

FACT: According to the 1977 health Interview Survey of the National Center for Health Statistics, there were about 1,391,100 severely visually impaired persons in the non-institutionalized population, of whom 71% or 990,000 persons were elderly. The projected # of severely visually impaired older persons by the year 2000 will increase to an estimated 1,756,000.

FACT: According to a 1978 Research Study in The Journal of Visual Impairment and Blindness, there were about 1,709,000 low vision or partially sighted persons of whom 48% were elderly, or about 824,000 persons.

FACT: According to a 1977 Nursing Home Survey of the National Center for Health Statistics, 3% of elderly residents were unable to see and another 26% were partially or severely visually impaired, giving a total of about 344,000 elderly nursing home residents who were visually impaired.

FACT: According to these statistics, therefore, almost 25% of the elderly population suffer from some sort of visual impairment, a conservative estimate of 6 million Older Americans.

FACT: Most visually impaired older persons live in their community and not in institutions. Among the severely visually impaired elderly, almost 2/3 live in their own homes, while the remaining 1/3 reside in institutions.

FACT: Rates for severe visual impairment are higher for older women than for older men. Almost 50 of every 1,000 elderly women, compared with 37 of every 1,000 elderly men, are severely visually impaired.

FACT: Certain minority groups (e.g. Blacks, Hispanics and American Indians) are more vulnerable to vision problems throughout life. Among the elderly, almost 42 of every 1,000 whites are severely visually impaired, but over 71 of every 1,000 non-whites are severely visually impaired.

FACT: Most SVI older persons are multiply impaired. An estimated 66% have at least one other impairment, such as absence of extremities or other organs, orthopedic impediments, paralysis, or deafness/hard-of-hearing.

FACT: Rates of visual impairment are highest among the "old-old", the fastest growing segment of the elderly population.

Table I, U.S. Population by Age, 1977 and 2000 (projected)

Age	1977	2000	Percent Change
Birth - 64 yrs.	193,315,000	228,556,000	+18%
65 yrs & over	23,430,000	31,822,000	+36%
65 - 74	14,577,000	17,436,000	+20%
75 - 84	6,813,000	10,630,000	+56%
85 & over	2,040,000	3 756,000	+84%
Total	216,743,000	260,378,000	+20%

Table II Projected Number of "Severely Visually Impaired" Elderly Persons in the Year 2000 Based on 1977 NCHS Health Interview Survey Prevalence Rates

Age	NCHS Prevalence Rates U.S.-1977 (number per 1,000)	Projected Number of "Severely Visually Impaired" Elderly Person: U.S.-2000
65-74 yrs.	22.0	384,000
75-84 yrs	64.9	690,000
85 yrs & over	181.5	682,000
Total elderly persons	-	1,756,000

Table III Projected Number of Legally Blind (LB) Persons in the U.S. in the Year 2000 Based on Adjusted 1970 MRA Prevalence Rates in Three "Representative" MRA States.

Age	LB Prevalence Rate 3 states - 1970 (number per 1,000)	Projected Number of Legally Blind Elderly Persons U.S. - 2000
65-74 yrs.	5.8	101,000
75-84 yrs.	12.8	136,000
85 yrs and over	34.6	130,000
Total elderly persons	-	367,000

What other facts have implications for the Older Americans?

FACT: According to the National Society to Prevent Blindness, the most common diseases associated with geriatric blindness are, in declining order of prevalence.

1. Macular Degeneration
2. Glaucoma (non-congenital)
3. Senile Cataract
4. Diabetic Retinopathy

5. Optic Nerve Atrophy

FACT: Vision loss for an older person often involves:

1. Loss of self-esteem and self-confidence

2. Loss of self-independence in the home and community

3. Loss of economic security

4. Loss of mobility

5. Loss of social contact

6. Loss of effectiveness in remaining senses

7. Loss of personal security

FACT: According to the American Academy of Ophthalmology, an estimated 50% of all geriatric blindness is preventable with proper preventive care and regular medical eye examination. The National Center for Health Statistics estimates that only a small percentage of the one and one-third million older persons with severe visual impairment are totally blind. Many of the remaining severely visually impaired older persons do have functional sight and can be helped by rehabilitative services.

II ISSUES SURROUNDING THE LATER YEARS

1) The aging population is not only growing larger but also is growing older. The "old-old" population 85 and over, is expected to increase 86%, 75 and over by 54% by the year 2000. The increase in the "frail elderly" has significant impact upon both the aging and blindness systems. The resulting aging population raises serious issues:

- a growing number of visually impaired elderly in institutionalized settings

- an increase in the number of multi-handicapped older persons

- an increased need for in-home services to enable elderly to remain in home and communities

- a dramatic growth in the need for specialized services for the "new" blind - rehabilitation, orientation and mobility, recreation, low vision, counseling, independent living skills, etc.

- the necessity for more effective, coordinated service delivery systems focusing all available community resources on needs of visually impaired older persons.

2) The growing number of elderly in all age populations will involve an increase in a new visually impaired population without training for independent life skills. This population will require:

- greater outreach efforts to identify this vulnerable population

- universal pre-screening to prevent unnecessary increased vision loss

- specialized rehabilitation training

3) This new population will also require specialized training of professionals and para-professionals in both the Aging and Blindness fields. This will require:

- greater networking between both systems
- new curriculum on Aging and Vision Loss in both educational systems
- increased in-service training on all levels
- increased publications, educational materials, film, etc. for all levels
- stronger committment to training

4) These increased service and training requirements will necessitate legislation changes on all levels of governments:

- re-examination of Rehabilitation Act to insure more funding for independent living training
- prioritizing of "visually impaired" in re-authorization of Older Americans Act
- Increased State and local funding in rehabilitation skills
- greater involvement of private funding in the area

APR 25 1984

AMERICAN PUBLIC HEALTH ASSOCIATION
1015 Fifteenth Street, N.W., Washington, D.C. 20005 • (202) 789-5600

Susan S. Addiss, MPH, MUrS, *President*

April 18, 1984

The Honorable Ike Andrews
2201 Rayburn House Office Bldg.
Washington, DC 20515

Dear Mr. Andrews:

The American Public Health Association, representing a combined national and affiliate membership of more than 50,000 public health professionals and community health leaders, supports h.R. 4472, the Older American Personal Welfare Education and Training Act. This Act would establish a new title to the Older Americans Act which would add health education and training to the services already provided to senior citizens who participate in Older Americans Act programs.

The basic concept of this bill is to provide services to the elderly through the more than 3,000 senior citizen centers around the country. Services will be provided by graduate students in health education. We support the provision of services through facilities where the elderly already congregate and the utilization of graduate students for this purpose. We urge that in addition to graduate students in Schools of Public Health, the program be open to graduate students in other accreditated health education programs as well.

The American Public Health Association commends your leadership in introducing this legislation, and looks forward to working with you towards its passage.

Very truly yorus,

Susan S. Addiss

Susan S. Addiss, MPH, MUrS
President

April 23, 1984

The Honorable Ike Andrews
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Again, we (the Deans of the U.S. Schools of Public Health) wish to commend you for successfully reporting out your bill H.R. 4472, the "Older Americans Personal Health Education and Training Act." We strongly support your continuing efforts on behalf of our senior citizens in this country. The Deans are particularly enthusiastic about your bill because it recognizes the important role (especially in design of programs) the Schools can play in improving the health status of the elderly, while at the same time help to control spiraling costs of medical care.

We would also like to commend Gordon Raley's fine work on behalf of this bill.

Sincerely,

M Gemmell

Michael K. Gemmell
Executive Driector

cc: Deans, Schools of Public Health

mic

ASPH
ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

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COUNTY OF ORANGE

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801-C NORTH BROADWAY
SANTA ANA, CALIFORNIA 92701
(714) 834-6017

April 23, 1984

Congressman Ike Andrews
House Select Committee on Aging
Rayburn House Office Building, Room 2201
Washington, D. C. 20516

Dear Congressman Andrews:

The Orange County (California) Senior Citizens Advisory Council, representing the interests of more than 335,000 county residents over 55, has voted to support in principle your H.R. 4472.

As you know, this bill would create Title VII of the federal Older Americans Act and would establish for seniors personal welfare and education programs in every senior multipurpose center. We would welcome a current status report on your legislation.

Our support in no way reflects the position of our county government but rather is the view of the elderly community in California's second largest most populous county.

Please let us know of any help our Council can provide in support of advancement of H.R. 4472.

Your assistance to elderly Americans is greatly appreciated.

Sincerely,

FR:rks

Fred Roth, Chair
Senior Citizens Advisory Council

JUN 8 - 1984

501 Hacienda Ave
Apt B-3
Campbell, Ca. 95008
June 4, 1984

Congressman Ike Andrews
Capitol Office Bldg.
House of Representatives
Washington, D.C. 20015

Re: H.R. 4472

Dear Sir,

Your concept of Health Education for Seniors as a prevention against illness, is one that I am in accord with.

I applaud your efforts in our behalf and sincerely hope you succeed in your endeavor.

Very truly yours,
Ida Gold

JUL 2 1984

June 25, 1984

The Honorable Ike F. Andrews
Chairman,
House Education and Labor Human Resources
Subcommittee
House Office Building
Washington, D.C. 20501

Dear Representative Andrews:

I am a Registered Dietitian and an Associate Professor at The University of Texas at Austin where I teach nutrition. I am writing you to stress the need for strengthening the law with regard to food safety, guidelines for individuals with nutrition expertise and nutrition education for the elderly in the reauthorization of our Older American Act.

Typically about one-half federal funds under the Older American Act are spent on food service, while the State of Texas does not have a nutrition position in the agency. A law should require each state agency to have a qualified dietitian position to assure our older citizens of the quality and kinds of dietary needs they require.

Research has shown that the elderly are quite capable of learning and will respond to nutrition education when carried out by a qualified dietitian. As a result of the way the law is written, nutrition education is sold short in Texas. The limited funds in the Title III C budget are spent on meals. I encourage you to include appropriations for nutrition education for the elderly.

In the rural parts of Texas, the Health Department does not visit the kitchen on a regular basis. The law needs to support State agency's efforts to monitor and provide technical assistance related to food safety.

Desperate needs have been identified in Texas for nutrition funds for trainers to provide adequate dessimination of information for meal safety, meal quality and promotion of good health.

Dietitians that work with the elderly in Texas are counting on you to strengthen the Older American Act to encourage greater concern for proper execution of the nutrition component. I would like to urge you to do all within your power to help make strides in improvement of the law.

Sincerely,

Margaret Briley

Margaret Briley, Ph.D., R.D.

MB:mp

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

APR 24 1984

The Honorable Carl D. Perkins
Chairman, Committee on Education
and Labor
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This is in response to your request for the Department's views on H.R. 4472, a bill "To amend the Older Americans Act of 1965 by adding a new title relating to multipurpose senior centers education and training."

In summary, we oppose enactment of the bill, since the activities it would require can be carried out, and to a considerable extent are being carried out, under existing authorities in titles III and IV of the Older Americans Act of 1965 (OAA). We strongly favor the bill's objective of encouraging the establishment and operation of more education and training programs in senior centers, and, as indicated below, we are in the first stages of an ambitious health promotion campaign.

The bill would add to the OAA a new title VII, entitled "Older Americans Personal Health Education and Training Program." It would authorize appropriations of $8.55 million for fiscal year 1985 and such sums as necessary for fiscal years 1986 and 1987 to enable the Secretary of this Department to enter into agreements with public and private institutions of higher education with capability in public health to establish and operate local or statewide demonstration health education and training programs, to be coordinated with multipurpose senior centers established under title III of the OAA. Before awarding funds for a project, the Secretary would be required to determine that it met detailed criteria. Among other criteria, the project would be required to be amenable to eventual replication in multipurpose senior centers and other sites throughout the Nation; to use multipurpose senior centers established under title III of the OAA; to address specific problems encountered by the elderly, such as diet, mental health, hypertension, retirement, health insurance, hypothermia and legal advice on rights to medical care; to provide education in the use of prescription and nonprescription medicines; to address the motivation of individuals and the benefits the elderly can derive from behavioral and lifestyle

modification within individual control; to provide for the training and utilization of graduate students and faculty in public health and the medical sciences, volunteers, and older American participants themselves; and to insure that participating older Americans are made aware of the health services available to them in their communities.

This Department has a keen appreciation of the importance of health education of the Nation's older population and of the benefits which result both for the older individuals who are thus educated and for the general public. The quality of the older individual's life can be greatly improved to the extent that he or she well learns the lessons of health maintenance and illness prevention and acts accordingly. Not only does the older individual avoid the agony or helplessness of illness or disease which can be prevented, but he or she enjoys good health, without which the best quality of life is difficult or impossible at any age. To the extent that such health maintenance and illness prevention efforts succeed, the public benefits in decreased costs of Medicare, Medicaid, and other public and private mechanisms which defray health care costs.

Because this Department has, for many years, recognized the importance of health education of the elderly, we have carried out a variety of activities to further this objective. Perhaps the most significant activity of this type which is being carried out during 1984 is the special health promotion campaign to improve the health status of older Americans, which will be launched by this Department during May, Older Americans Month, the theme of which is "Health: Make It Last a Lifetime." This effort will be coordinated by a task force under the joint leadership of the Administration on Aging (AoA) and the Public Health Service (PHS). These components of this Department have joined together in a multiyear cooperative effort to help States and communities to develop health promotion activities for older persons under the authorities of the Older Americans Act and the Public Health Service Act.

The key objective of this strategy is to facilitate collaboration between State and local health departments, State and Area Agencies on Aging, and appropriate voluntary organizations in the development of health promotion programs for older persons at the community level in the areas of injury control, proper drug use, nutrition, and physical fitness. AoA and PHS will provide both the leadership to initiate this effort and additional materials for use in this initiative. The primary document to be made available for use in this effort will be

A Healthy Old Age: A Source Book for Health Promotion with Older Adults, which was developed by the University of Washington under an AoA training grant. It provides a comprehensive framework for the organization and conduct of health promotion activities at the community level. Other materials will be sent during the coming year as they are developed and issued by AoA and PHS.

Other activities to meet the health education needs of the elderly have been carried out within this Department for many years and will continue. The National Institute on Aging publishes and distributes through the mail and displays at retail pharmacies booklets and leaflets on various types of health problems and opportunities of the elderly. The PHS Center for Disease Control has published a manual, "Nutrition Education for the Elderly," for use in Older Americans Act nutrition programs and by local health departments and voluntary organizations which are involved or interested in nutrition for the elderly.

Thus, this Department has adequate authority under present law to carry out programs of health education for the elderly, and is making full use of that authority; H.R. 4472 would merely duplicate that authority and provide for excessive appropriations for these programs.

This Department supports extension of the current programs under the Older Americans Act of 1965 which is now under consideration within your Committee and other congressional committees. We transmitted to the Congress on March 27, 1984 the Department's proposal to extend and amend the Older Americans Act programs, which has been introduced as H.R. 5325. This bill was developed and proposed after careful review of the OAA and its current operations, and contains the only changes we believe are needed.

We therefore recommend that H.R. 4472 not be favorably considered. We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administrations's program.

Sincerely,

/s/ Margaret M. Heckler

Secretary

Toward A National Policy On Aging

Proceedings of the

1971 WHITE HOUSE CONFERENCE ON AGING

November 28 – December 2
Washington, D. C.

Volume II

Conference Findings
and Recommendations
from the Sections and
Special Concerns Sessions

SECTION ON PHYSICAL AND MENTAL HEALTH

"Compulsory health care inevitably results in poor quality health care."

SECTION ON HEALTH AND MEDICAL CARE, 1961 WHITE HOUSE CONFERENCE ON AGING

"It is distressing to be told . . . that the quality of care the individual physician renders will be influenced by the source of payment. We do not believe this is so."

MINORITY REPORT, SECTION ON HEALTH AND MEDICAL CARE, 1961 WHITE HOUSE CONFERENCE ON AGING

INTRODUCTION

The report of the first (1961) White House Conference on Aging, *The Nation and Its Older People*, clearly reveals the debate at that meeting which raged over the provision and financing of health care to the elderly.

Now, ten years later, it is possible to point to demonstrable outcomes of that debate, namely the evolution of vast change in the whole realm of health care and public policy. At the same time, however, long-recognized deficiencies in the traditional system of health care remain. And, programs adopted to make the system more responsive to the circumstances of those most disadvantaged within it—the elderly and the poor—fashioned in controversy, remain under intense critical review. Medicare and Medicaid, recognized for their strengths, are equally noted for their deficiencies. Attention is now being focused on the adoption of a comprehensive national health plan, but there is concern about the alterations its adoption might bring about in the quality and delivery of health services to the elderly.

Over 480 Delegates to the 1971 White House Conference on Aging were named to participate in the deliberations of the Section on Physical and Mental Health, the largest of any of the 14 Conference Sections. Among the Section participants were over 100 physicians, including specialists in such areas as geriatrics and psychiatry; over 50 association executives working in health, social welfare, and related fields, including the insurance industry; over 35 administrators of hospitals, extended-care facilities, nursing homes, mental health clinics and outpatient centers, or other such health facilities. Nurses, optometrists, podiatrists, psychologists, pharmacists and rehabilitation workers serving the blind, the deaf, and other physically disabled, were members of the Section. So, too, were researchers and professors of medicine, nursing, sociology, health care administration, and persons serving within health and welfare agencies at local and State levels.

By virtue of their age, over 13 percent of the Section body could speak directly to the various health services still out of reach for a large share of elderly persons, largely because of costs, lack of facilities, and the fragmentation of health care delivery systems.

In offering nine major proposals, these Delegates, sensitive to what has passed and what remains to be done, addressed such topics as: the need for separate health services for the elderly; the coordination and delivery of health services; Medicare, Medicaid, and the alternatives offered

through adoption of a national health insurance program; a national program of education about specific health changes and diseases associated with aging; the adequacy of the supply and training of health manpower; and the balance to be achieved among expenditures for research, training, and services.

SECTION REPORT

Convened in an initial orientation session, Delegates to the Section on Physical and Mental Health heard Co-chairman Edward J. Lorenze set forth the parameters for the work of the Section and its Subsections over the course of the next several days. At the request of presiding Co-chairman James G. Haughton, Dr. Lorenze offered his remarks highlighting the topical areas which would likely be a major concern to the Delegates in their deliberations.

Co-Chairman's Statement

It gives me great pleasure to welcome the Delegates to the Physical and Mental Health Section of the 1971 White House Conference on Aging. As you may know, you number over 400 delegates and constitute the largest Section of the Conference. This fact, as well as the responses in the State and regional White House Conferences, indicates that health care in its broad aspects, including both physical and mental health, continues to be a major concern of the American people.

This concern is not limited to those at or near the arbitrary age of 65 years, but involves the entire population. This concern continues for the elderly, despite the fact that since the 1961 White House Conference on Aging, major public policy decisions have been made in regard to the Title XVIII and Title XIX programs of Medicare and Medicaid which have profoundly affected the delivery of health care services to the elderly for the better. Indeed, among some, it has been felt that programs for the payment of health services have made those over 65 a privileged group. Progress has been made, but much remains to be accomplished.

The issues which were developed by the Technical Committee on Health, which I had the honor to chair, were developed to stimulate discussion in a number of broad areas concerning the delivery of quality health services. They were designed not to limit the areas to be considered, but to provoke discussion and difference of opinion and recommendations from a broad segment of the population, involving the consumer, the deliverers of health services, laymen and professionals, individuals and national organizations with a particular concern in this area. The issue questions have been discussed at the White House Conferences of the several States and by local conferences within the States, as well as by the national organizations.

The program recommendations which have come out of these deliberations have been tabulated and integrated, and appear in your Work Books under each of the issue questions. Thus, the Work Book contains the results of national discussion. The issue questions and the recommendations of these groups, plus your own contributions, are the subject matter for this Conference which we are about to begin.

You will be divided up into 13 groups, each of which will consider all the health and mental health issues, and determine the recommendations which you feel appropriate. We anticipate that the recommendations coming from this process will provide guidelines which are an expression of the will and the wisdom of people on all levels, and from which will be developed a blueprint which will have profound effect upon the health care delivery system and the quality of care which will be provided.

As I have thought over the issues and possible recommendations, the following areas seem to me to be of major concern in your deliberations.

1. A recognition of the fact that, while many health services are provided to the older segment of the population, obvious gaps and deficiencies exist. The identification of these gaps and inconsistencies will be a major concern. It should be recognized that a coordinated system of comprehensive health services is the objective, not inde-

37-680 O—84——26

pendent and fragmented services without provision for continuity of care.

2. The goal of comprehensve health services is difficult to achieve without a coordinated system for a variety of reasons, incuding ignorance of one's needs, financial or geographical considerations which limit access to services which are available, lack of facilities and personnel to deliver the services. The quality of care provided will also be dependent upon the supply of manpower and the ever improving results of research. We should be aware that the product the delivery system brings to us must be a continually improving one. The medical care of 1900 is not the medical care of 1970 and the medical care of 1970 will not be the care of 1980. The necessity for continued research to improve the product is self-evident. We might be able to get along with the 1930 automobile, but no one would accept the quality of medical care of 1930, which was then available to the most privileged in our society.

3. The elderly, despite gains in the area of Federal programs for payment of health services, continue to require special attention to their needs because of their particular social and economic vulnerability, as well as the fact that in the older age group, the incidence of disease, disability and need for health care services of all kinds is so great. We must examine the special needs within this group of those who are impoverished and those who, because of racial and ethnic origin, have been particularly isolated from the main stream of the existing health care delivery system. The rural and urban ghetto areas, particularly, have had limited resources in terms of facilities and personnel needed to meet their health care requirements. The distribution of these services must be reconsidered and new and innovative ways must be developed to provide for them. The role of regional health facility planning and, indeed, health personnel distribution, must be developed and expanded on a national basis if the goal of comprehensive health care is to be achieved. This must include provisions for health education and preventive services, diagnostic and therapeutic services, rehabilitative services and programs for long-term care with alternate methods to institutional care.

4. Consideration must be given to the fact that, while the achievement of these services for the elderly is our immediate and primary concern, in a larger sense we recognize that such a program must be available to all of our people, whatever the age. It is not conceivable that a system of this kind can be developed for the elderly to the neglect of other age groups. Our network of facilities, including physicians' offices, health care centers, clinics, hospitals, rehabilitation centers, long-term care facilities and home care programs, must all be of high quality in providing both for the old and the young. It would be difficult to conceive that separate facilities, such as general hospitals, would be developed only for the elderly, but should continue to provide for all age groups. However, it may be some time until such a system becomes an actuality and the aged might well be considered a trial group for which this type of comprehensive health care program could be worked out, and would provide the experimental basis on which developments for the other segments of the population would come about.

5. A variety of national health care plans have been suggested. These have primarily dealt with financing of such care for our population. Probably nothing that could be considered a truly satisfactory comprehensive health care system has been outlined, nor have the details been spelled out. It may well be that it will be a considerable time before a comprehensive program for a national health plan will be developed.

In our deliberations, we must stress the nature of the program that we would like to see developed. We should take care that our recommendations do not work adversely to the interest of the elderly or that gains which have already been made are lost. The attitudes toward the deficiencies in Medicare and Medicaid should be reviewed in the light of expanding the legislation and financing and not provide the opportunity for cutbacks and limitation.

6. We must remember that in this country we do have a system of delivery of health care services which, although failing to meet all of the needs of all of the people all of the time, has, nevertheless, provided tremendously effective service to a large population. It is the imperfec-

tions in this system which we are stressing, but one would have difficulty in finding examples of countries which have provided a quality of care on the scale which we have achieved. We want improvement, but we should not be ashamed or apologetic of the achievements to date.

7. There are many States in this country where the provisions under Medicaid have been quite broad for the elderly. The question to be examined is why there are inequalities in the level of services provided across the Nation, and would bring us to ask why the quality of care and extent of services covered should not be national in scope and not vary from State to State. It would appear only right that the minimal standards of care acceptable should be national in scope and provision. Likewise, regional planning for health facilities and services should have a similar national scope as should the regulations and supervision of these services, so that the amount and quality would not vary from one area of the country to another.

8. Another matter to be considered is whether access to comprehensive health services should be a matter of right to all elderly people, regardless of ability to pay. A major criticism of the Medicaid program, even in the States in which a broad spectrum of services are available, is the fact that it is not a right available to all elderly persons but is based on a means test. The Medicare program and the services provided by it are a matter of right and not limited by economic need. These are financial and philosophical questions which will require considerable thought before satisfactory solutions are determined. One would have to consider whether health care, like public education, is a basic ingredient to the continuation of a successful free society such as we have developed.

9. I would particularly stress that we not lose sight of the problems in mental health. There are many who feel that lip service is given to this area, but that it is frequently then overlooked. It is clear that our concern is with the total health needs of the individual and that the physical and mental aspects cannot be separated in our program development, just as they cannot be separated in the individual human being.

In conclusion, we are embarked on a voyage of major importance. The policy recommendations which you will develop will, undoubtedly, have profound effects on the course which our society will follow in the next ten years. I am sure that changes will occur between this and the next White House Conference on Aging which will far surpass the changes which have occurred since the Conference of 1961. I wish you well in your deliberations and I feel secure that you will provide clear guidance to those who will be charged with the development of the health care system of the future.

Preamble

We, the Delegates to the Physical and Mental Health Section of the 1971 White House Conference on Aging, assert that the United States of America must guarantee to all its older people health care as a basic right and a quality of life consistent with that in which our Nation should assure to this group who have made invaluable contributions to its development. In order to assure that quality of life, a basic requirement is the availability of a comprehensive system of appropriate health care.

A comprehensive system of appropriate health care requires that full spectrum of presently known services be readily accessible. These must be of high quality and be delivered in the appropriate setting and at the appropriate time, with concern for the dignity and choice of the individual, and within a framework which guarantees coordination among the various levels of care, continuity of care over time, and the efficiency and effectiveness which will assure supportable costs.

To be comprehensive and systematic, this health care must provide:

a. Assessment of health
b. Education to preserve health
c. Appropriate preventive and outreach services
d. All physical, mental, social, and supportive services necessary to maintain or restore health
e. Rehabilitation
f. Maintenance and long-term care when disability occurs

To be specifically responsive to the needs of the elderly, special attention must be given to the availability and quality of long-term care and to the development of adequate, appropriate alternatives to institutional care.

Community and consumer participation in the planning and delivery of such a system of services will tend to assure the responsiveness of the system to locally defined community need and the appropriate use of health manpower, facilities and financing.

The Health Section recognizes that although the aged represent a minority, within this minority there are special problems experienced by racial and ethnic groups. Within the special concern expressed for the problems of the aged, particular attention must be accorded to make sure that these minorities are not doubly jeopardized.

In support of these basic premises the Physical and Mental Health Section submits the following policy proposals.

Recommendations

RECOMMENDATION I
Special Health Care

Health care for the aging must be provided as an integral part of a coordinated system that provides comprehensive health services to the total population, but immediate and special consideration and emphasis must be given to the problems of, and services for, the aging.

RECOMMENDATION II
Coordinated Health Services Delivery System

A coordinated delivery system for comprehensive health services must be developed, legislated, and financed to ensure continuity of both short- and long-term care for the aged.

RECOMMENDATION III
National Health Insurance and Medicare

A comprehensive health care plan for all persons should be legislated and financed through a national health plan. Pending the achievement of such a national health plan, the complete range of health care services for the elderly must be provided by expanding the legislation and financing of Medicare.[1] Such expanded financing should be accomplished by means of a combination of Social Security trust funds with a greatly expanded use of general revenues. Such expansion of Medicare should include elimination of deductibles, co-insurance and co-payment, and all provisions discriminatory to the mentally ill, as well as the establishment of congruent ages for Medicare and Social Security benefit eligibility. Both the immediate expansion of the current program and a future national health plan should provide for a public-private partnership in the delivery of services and for Federal financing and quality controls in order to assure uniform benefits and uniform application of the standards of quality. Centralized responsibility for standards and controls over health facilities and services must be combined with protection, for the patient and provider, from arbitrary, capricious, and varied application and interpretation of existing as well as new standards.

Minority Recommendation

The fiscal aspects of the Medicare program should be administered by the Federal government rather than by the private insurance carriers as intermediaries.

RECOMMENDATION IV
Health Education for All Ages

A continuing national program for education of all persons should be provided about the specific physical, mental, and social aspects of aging. Educational programs should be addressed to all ages and should include all stages of development so that the different age groups will better understand each other. Information on all aspects of aging should be included in educational courses at all levels. The aged themselves should be among those recruited, trained, and utilized in carrying out these programs.

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[1] A minority opposed the Section's action eliminating the combination of Medicare and Medicaid expansion (through legislation and financing) as an alternative to the expansion of Medicare alone in order to achieve a comprehensive health care plan.

RECOMMENDATION V
Training in Aging for Health Manpower

Emphasis should be placed on including curricula or course contents on physical, mental and social aspects of aging in secondary schools, undergraduate professional education, and in inservice training and continuing education of health personnel. The development of specialists in the care of the elderly should also receive emphasis, especially with the view of developing professional, allied health professional, and other health personnel selected and trained to give compassionate and expert care to the aged. Funds must be provided to ensure the development of such programs as well as increase the supply of health manpower of all kinds.

RECOMMENDATION VI
Funding for Research, Service, and Education

The aging will best be served if available funds are divided among service, research, and education. Emphasis should be placed on funding of direct services but not to the exclusion of research and education, which should receive a reasonable proportion of total resources available. Research findings now available should be assembled, coordinated, and incorporated into service programs.

Specific attention should be given to increasing the funds available for basic research and for operational research with a strong suggestion that a gerontological institute be established within the National Institutes of Health to provide the essential coordination of training and research activities.

RECOMMENDATION VII
National Mental Health Center for Aging

A center for aging should be established in the National Institute of Mental Health to meet the responsibilities for more research and training in the field of mental health of the elderly.

RECOMMENDATION VIII
Presidential Commission on Aging

The President and Congress should authorize the appointment of a commission on aging, including a committee on mental health of the elderly, comprised of representatives from concerned Federal agencies, national organizations, Congress, and the Judiciary, and private citizens to study, evaluate, and recommend a comprehensive set of policies for the Federal government, the several States, and local communities to pursue in this vital area.

RECOMMENDATION IX
Protection of Individual Rights

Congress should appoint a nationwide interdisciplinary committee to determine the scope and type of intervention procedures and protective services that would clearly protect the rights of the individual with health, mental health, and emotional problems requiring care. The rights of his immediate family and other close associates should be considered. This committee should include representatives of the religious, civil rights, civil liberties, legal, health and social services communities. Congress should appropriate sufficient funds to assure an indepth study of all aspects of the individual's rights in relation to his needs for health services and the administration of his affairs until he can resume responsibility.[1]

Intervention procedures and protective services also should assure for elderly individuals their rights of self-determination in their use of health facilities and services.

In order to promote and encourage the establishment of ombudsman services, the nationwide interdisciplinary committee, or other suitable means, should be used to study and define the functions and roles of ombudsmen as separate and distinct, conceptually and in practice, from other protective services and from consumer participation in health and other matters affecting the elderly. Subsequent promotion of ombudsman services should include financial support for their activities, as well as programs to assure that their functions and findings are given full visibility at local, State, and national levels, and in both the public and private sectors.[2]

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[1] A minority requested the Section to substitute the words "physical and mental health" for the amended word "health".
[2] A minority requested the Section to eliminate the last paragraph referring to ombudsman services.

Final Report the 1981 White House Conference on Aging

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Chapter 3

HEALTH CARE FOR THE ELDERLY

INTRODUCTION

Health care may be the most important issue to the elderly. After economic issues, health issues received the most comments from both delegates and observers to the 1981 White House Conference on Aging. Although the elderly make up only 11 percent of our population they consume 29 percent of total health care expenditures and 50.5 percent of Federal health care (nonmilitary) expenditures. As our population ages the percent of Federal health care dollars absorbed by the elderly will inevitably increase. It is precisely because of the Federal Government's major role in financing their health care that older Americans are so concerned about its rising cost.

For most goods and services the marketplace determines the worth of a product and how much of the Nation's total wealth should be spent on it. Individuals spend their incomes as they see fit, and the sum of their independent decisions is accepted as society's judgment. Rarely is there public debate over the share of the Nation's Gross National Product going to sports cars or expensive suits.

In contrast, the share of GNP going to health care is often discussed in scholarly research, newspaper commentary, and Congressional hearings. For reasons that will be discussed below, many informed observers consider the Nation's growing spending on health care a sign that something is seriously wrong with the health care system, and not a reflection of considered individual and public choices about the worth of its services.

Across the entire spectrum of opinion, there is agreement that the cost of medical care is one of the most pressing health policy issues. More and more Americans are asking: Can we afford to spend so much on health? Can't we at least make the health care system more efficient and cost-effective?

This chapter presents background and basic analysis on why health care spending has been rising, how people have benefited from the growth in spending and how we might improve the efficiency of the system. At the end of the chapter, special attention is devoted to long-term care and preventive medicine and health promotion.

THE GROWTH OF PRIVATE AND PUBLIC HEALTH INSURANCE

The substantial growth in the share of the Nation's wealth going to health care has corresponded with a substantial expansion of private and public health insurance. In 1950, 65 percent of all health care expenditures were paid by the patient. By 1980, the share paid

out of pocket has shrunk to 10 percent.[1] For some services, most notably hospital care, the patient pays even less than 32 percent out-of-pocket. As Table 1 shows, the share of the cost of an average hospital day that is paid on receipt of services declined from 30 percent in 1950 to 9 percent in 1980.

TABLE 1. – Out-of-pocket share of daily hospital costs, 1950 and 1980

	1950	1980
Average cost per hospital day (nominal dollars)	$15	$245
Average cost per hospital day (1967 dollars)	$22	$ 99
Percentage paid out-of-pocket	30%	9%
Out-of-pocket payment per day (1967 dollars)	$ 7	$ 9

Source: Feldstein, Martin S.; Amy Taylor, 1977, The Rapid Rise of Hospital Costs. Washington, D.C.: U.S. Council on Wage and Price Stability (data updated and revised to be consistent with Gibson, Robert M.; Daniel R. Waldo, 1981. "National Health Expenditures, 1980," Health Care Financing Review 3:38).

While the real, inflation-adjusted, cost of a day in the hospital increased from $22 in 1950 to $99 in 1980 (a 450 percent increase), the amount the average patient pays out-of-pocket increased only from $7 to $9 (a 29 percent increase). Thus, while the amount of economic resources going to hospital care grew dramatically, the prices seen by patients suggested to them a much more modest growth.

Reasons for the Growth of Private Insurance

Health insurance and medical prepayment began to grow rapidly in the 1920s as people were attracted to both the financial protection it offered and the sense of security that came from being able to seek medical care without having to worry about the cost of each physician visit. After some initial reluctance, hospital and physician groups also supported the growth of private health insurance, ultimately sponsoring their own Blue Cross (hospital) and Blue Shield (physician) plans beginning in the 1930s and 1940s. Among other things, provider groups viewed insurance as a way to increase the ability of patients to pay for medical care, thus reducing provider bad debts which had increased dramatically during the Depression.[2]

Many economists believe the growth of insurance was also stimulated by the preferential treatment given health insurance under the income tax code.[3] Since World War II, employer-paid health benefits have not been counted as part of a worker's taxable income, thus encouraging employers to purchase health insurance for their workers in lieu of some of the cash wages they would otherwise pay.

Currently, the average marginal tax rate on employment income (combining Federal income tax, employer and employee share of the Social Security tax, and State income tax) exceeds 40 percent — that is, the average worker pays more than 40 cents in added taxes for each dollar increase in his cash wages. Thus, by exempting employer-paid health insurance from these taxes, the tax law permits insurance to be purchased at what amounts to more than a 40 percent discount. Paul Ginsburg of the Congressional Budget Office has estimated that eliminating this special treatment for employment-based insurance would cause "a substantial decline in the proportion of [medical] expenses covered by insurance . . . ,

possibly about 25 percent."[4]

With this stimulus from the tax law, employment-based insurance has become one of the most popular fringe benefits. Between 1950 and 1980, private insurance payments for health care increased from $1 billion to $58 billion, while the percentage of all health care expenditures paid through private insurance increased from 9.1 percent to 26.6 percent.[5] In 1979, about 171 million Americans (about 76 percent of the population) were covered by private insurance plans,[6] mostly employment-based. Furthermore, there is a trend toward more extensive employment-based plans, with coverage for dental care, prescription drugs, vision care, and outpatient mental health care becoming increasingly popular. Some employers now also continue health insurance coverage for retirees where it serves as a "medigap" plan supplementing the retirees' Medicare benefits. A 1980 survey of large employers found that 66 percent of the responding firms had such coverage for their retirees.[7]

The Evolution of the Public Financing Programs

Complementing the growth of private health insurance, Congress enacted a series of public financing programs that led ultimately to Medicare and Medicaid.[8] Public health insurance had its roots in the Social Security Act of 1935, under which the Federal Government began to share with the States the cost of extending cash assistance to the needy, the aged, the blind, single women with children, and later, to the disabled. The Act did not provide for direct assistance for medical expenses, but medical expenses were taken into account in determining the level of cash assistance going to an individual. In short, medical assistance was provided indirectly through the welfare system rather than through direct payments to providers. Participation by the States was optional.

The Social Security Amendments of 1950 marked another important watershed in the debate over public health insurance. That act provided for Federal matching funds to States that offered public assistance including medical payments to hospitals, physicians, and other providers of medical care. For the first time the Federal Government contributed to direct payments to providers of medical care. By 1960 about 40 States were participating in this program, spending about $500 million. During the 1950s, however, concern continued to grow about the increasing number of aged who did not receive public assistance and lacked adequate private insurance. Almost three-fourths of all health bills for the elderly had to be paid by the aged themselves or by their relatives. Moreover, the over-65 age group had average health expenses that were twice those for the rest of the population.

Concern about the health and welfare of the elderly supplied much of the political impetus behind the next major increase in Federal support of health care, the Social Security Amendments of 1960, also known as the Kerr-Mills Act. Under Kerr-Mills, the Federal share of medical assistance was increased, and the government made an open-ended commitment to pay for an established list of medical services. States were given the option of extending coverage (with Federal matching payments) to the elderly who did not require cash assistance but who were in need of assistance for medical care. By the end of 1965, all States were participating in the basic program, and 47 had coverage for these medically needy aged.

MEDICARE AND MEDICAID

Medicare

Enacted in 1965, Medicare is a Federal program providing hospital and medical insurance coverage to persons who are entitled to Social Security cash benefits and their families. Nineteen million elderly persons gained eligibility for Medicare at its inception in 1966. Medicare beneficiaries now number 25 million persons who are over 65 and 3 million who are permanently disabled, including 73,000 who are suffering from end-stage renal disease. Almost all the Nation's elderly population is covered by Medicare. Roughly three and one-half million Medicare beneficiaries also have Medicaid coverage.

Medicare covers the following acute and extended care services: hospital care, physician services, post-hospital skilled nursing facility (SNF) care, home health care, laboratory and x-ray services, physical and speech therapy, rural health clinic services, and durable medical equipment and supplies. Medicare covers neither outpatient prescription drugs nor long-term nursing home care, two services of considerable importance for the elderly.

Medicare consists of two parts: Part A, Hospital Insurance, and Part B, Supplementary Medical Insurance. All persons receiving Social Security retirement or disability benefits are automatically entitled to Part A without premium payments while anyone who is over age 65 or otherwise entitled to Part A benefits may elect Part B. Part A is financed primarily (97 percent) with payroll taxes and Part B is financed by a combination of general revenues (three-fourths of expenditures) and beneficiary premium payments (one-fourth of expenditures). Ninety-six percent of all Part A beneficiaries also enroll in Part B. Conversely, about 40,000 persons not eligible for Part A enroll in Part B. The monthly premium for Part B coverage is now $11.00 and will become $12.20 July 1, 1982.

Under Medicare Part A, most benefits are available on a spell-of-illness basis. A spell of illness is defined as the period that begins at the time a beneficiary enters a hospital and ends when he has been out of a health care facility for 60 days. During each spell of illness, beneficiaries are covered for 90 days of hospital care and 100 days of skilled nursing care. They are entitled to receive an additional 60 days of hospital care during their lifetime (called lifetime reserve days) and unlimited home health visits if they require a skilled home health service.

Medicare requires beneficiaries to pay part of the cost of services covered by Part A, although most of the cost-sharing is imposed toward the end of the benefit period. During each spell of illness, beneficiaries must pay a deductible amount ($260 for 1982) that approximates the national average cost of one day of hospital care. There is no cost-sharing for days 2 through 60. Coinsurance is charged for days 61 through 90 of each spell of illness (an amount equal to 25 percent of the deductible or $65 a day in 1982), and for lifetime reserve days (50 percent of the deductible). Coinsurance equal to one-eighth of the hospital deductible per day is charged for days 21 through 100 of skilled nursing facility care.

Cost-sharing is also required of beneficiaries under Part B of Medicare. Each year a beneficiary must meet a Part B deductible, set at $75 for 1982. Thereafter, Medicare reimburses the beneficiary for 80 percent of what it determines to be reasonable charges of physicians and other suppliers of services. The beneficiary pays the remaining 20 percent of the reasonable charges and, about half of the time, must pay the additional amounts charged by physicians that Medicare does not consider to be reasonable. Benefits paid under both Parts A and B of Medicare represent 44 percent of total personal health care expenditures for the elderly.[9]

Almost 70 percent of Medicare spending for the elderly is for inpatient hospital care, 25 percent for physician services, 2.5 percent for home health care, and 1.5 percent for SNF care.

Medicare program costs have risen at an average annual rate of 18.8 percent since 1972. By comparison, medical care prices in general rose 8.5 percent a year over the same period. In fiscal year 1982, Medicare costs will increase to more than $47 billion, double what they were in 1978. This dramatic rise in costs is due to both price and utilization increases, along with growth in the beneficiary population. In fiscal year 1982, Medicare will pay part of the health care bills of more than 17 million elderly beneficiaries, at an overall average cost of $1,696 per beneficiary.

Table 2 presents trends in Medicare total disbursements and expenditures per enrollee for selected years since 1967. In light of these trends, it is not surprising that public officials have expressed concern about the continued financial viability of the trust funds that pay the Hospital Insurance and Supplemental Medical Insurance expenses for Medicare beneficiaries. In March, 1982, the trustees of the Federal Hospital Insurance Trust Fund reported to Congress that expenditures from the trust fund could exceed revenues as early as 1986, and that even under the most optimistic assumptions the fund would be depleted in 1991.

TABLE 2. — **Total disbursements from the Medicare trust funds and disbursements per beneficiary for selected years, 1967-1982**

Year	Total disbursements (billions)	Mean disbursement per beneficiary*
1967	$ 4.46	$ 251
1972	$ 8.61	$ 429
1977	$21.62	$ 869
1982 (projected)	$47.75	$1,696

Source: 1981 Annual Reports of the Boards of Trustees of the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds, U.S. Government Printing Office, July 8, 1981.

*Pertains only to enrollees in the Supplemental Medical Insurance Program — slightly less than the number enrolled in the Health Insurance program.

Medicaid

Medicaid is a joint Federal and State program, administered by the States, that finances health services primarily for individuals who are eligible to participate in the Federally-supported welfare programs: Aid to Families with Dependent Children and Supplemental Security Income (SSI) for the aged, blind, and disabled. In addition, States may provide Medicaid to medically needy persons whose incomes are too high for the cash assistance programs but who would otherwise be eligible, and whose incomes are not high enough to pay for their medical care. Thirty States and four territories have programs for the medically needy.

Medicaid was enacted along with Medicare in 1965, and States first began to participate the following year. It was not until 1970, though, that the vast majority of States had joined the program. All States except Arizona now have Medicaid programs.

Certain basic services must be provided under any State Medicaid program: hospital services, physician services, laboratory and x-ray services, SNF services for persons at least

age 21, home health services, family planning, rural health clinic services, and health assessment services for children. States also may provide any of a variety of additional services that qualify for Federal matching funds. All States have chosen to cover intermediate care facility (ICF) services. There is great variation in State income eligibility standards, provider reimbursement levels and methods, and in the amount, duration, and scope of benefits.

Medicaid operates as a vendor payment program. Payments are made directly to providers, who must accept the Medicaid payment as payment in full. For nursing home care, individuals are required to contribute any income they have above the eligibility standard to help pay for the care. States may require medically needy beneficiaries to share in the cost of services provided to them. Forty-six State Medicaid programs have agreements with Medicare to pay the Part B premium on behalf of beneficiaries eligible for both programs.

Medicaid is financed jointly with State and Federal funds. Federal contributions vary with the States' per capita income levels and currently range from 50 percent to 78 percent of program expenditures. The distribution of Medicaid expenditures across services is very different from that for Medicare: just 31 percent for inpatient hospital care; 13 percent for physician, clinic, and outpatient department services; 42 percent for nursing home care; less than 1.5 percent for home health care; and almost 6 percent for prescription drugs. Medicaid payments account for 14 percent of the health expenditures of the elderly.

An estimated 23 million persons will receive Medicaid benefits in fiscal year 1982 at a Federal and State cost of more than $32 billion (the Federal share will be $17.8 billion). Medicaid expenditures have risen rapidly over the past 7 years at an average annual rate of almost 15 percent (1975-1982). Elderly beneficiaries, who represent only 15 percent of Medicaid recipients, account for over 37 percent of Medicaid spending.

Private Coverage and Out-of-Pocket Payments

Private insurance covers just 7 percent of health care expenses of the elderly, proportionately less than half of what it covered 16 years ago. More than half (about 55 percent) of the elderly purchase private insurance to supplement Medicare coverage. In 1977, approximately 12.2 million elderly Medicare beneficiaries purchased an average of 1.7 health insurance policies each, paying premiums that averaged $318 per year per beneficiary. For that year, the elderly spent a total of $3.8 billion on coverage supplemental to Medicare.

The private health insurance coverage the elderly have purchased to supplement Medicare has frequently been duplicative, expensive, and has not provided adequate protection against extraordinary expenses. Congress recently amended the Medicare statute to encourage States to adopt minimum standards for private health insurance policies specifically designed to supplement or fill in Medicare coverage (these are sometimes called "Medigap" policies). The standards for coverage, marketing, and premium-payout ratios for such policies are based upon those developed by the National Association of Insurance Commissioners. The law also provides for a voluntary Federal certification program to be implemented in States that fail to adopt adequate standards; the program is to begin on July 1, 1982. At the present time it is expected that the voluntary certification program will not apply in 45 States and jurisdictions because their Medigap programs meet Federal standards. Thus the Federal voluntary certification program will operate in only 10 States and jurisdictions.

The Medigap statute also provides new protections for Medicare beneficiaries by establishing Federal criminal penalties for certain fraudulent and abusive practices in

the marketing and sale of supplemental insurance policies. In addition, the Department of Health and Human Services and each of the States will continue their information and education efforts to teach Medicare beneficiaries about private supplemental health insurance.

Despite the availability of Medicare, Medicaid, and private insurance, the elderly still pay about 29 percent of their health care expenses directly out of pocket.[10] This is, however, a substantial reduction from the mid-1960s, when, as described in the next section, the elderly paid for more than half of their health care in this way.

IMPROVEMENTS IN ACCESS AND HEALTH STATUS

The Medicare and Medicaid programs have had a significant impact on the availability and affordability of health care services for the elderly. Before 1965, substantial segments of the population faced serious financial barriers to obtaining medical care. Only 50 percent of the elderly had any form of health insurance.[11] Under Medicare, almost all of the elderly are covered for hospital and physician services. In addition, Medicaid provides insurance coverage to over 20 million of the Nation's low-income population, including 3.4 million of the poorest elderly citizens. As Table 3 indicates, public health care programs finance almost two-thirds of the costs of medical care incurred by the elderly. This is in sharp contrast to 1965, when public programs financed only 30 percent of the elderly's health care expenses.

TABLE 3. - Personal health expenditures of the elderly population (age 65 and over)

Year	Aggregate amount (in billions)	Per capita amount	Percent public programs
1965	$ 8.9	$ 472	30
1970	$17.3	$ 854	61
1976	$37.7	$1,624	65
1980*	$68.4	$2,640	64

*Preliminary 1980 data. Provided by the Health Care Financing Administration.

Source: Charles R. Fisher, "Differences by Age Groups in Health Care Spending," Health Care Financing Review, Vol. 1, No. 4, Spring 1980.

Access to Medical Care

Public health care financing programs have led to marked improvement in the availability and accessibility of quality medical care.[12] Since 1964, access to and utilization of medical care services have increased most significantly among the low-income elderly population.[13] For example, hospitalization rates among the elderly have risen dramatically. The average number of days of hospitalization per year for persons over age 65 increased more than 20 percent between 1965 and 1975. This increase in hospitalization was also significantly higher for the poor elderly (47 percent) than for the nonpoor elderly (18 percent).

Also, there is greater equity in access to ambulatory medical care. In 1964, only 72 percent of the low-income elderly, in contrast with 82 percent of the higher-income elderly, had visited a physician within the prior 2 years. By 1979, parity was achieved with 86 percent of both groups having visited a physician. Similarly, the differential in annual rates of physician visits for low-income and higher-income elderly persons has been almost eliminated.

These notable achievements in facilitating access to medical care and promoting equity are dramatically reflected in the fivefold rise in per capita expenditures for health care services to the elderly, increasing from $472 per elderly person in 1965 to $2,640 in 1980. As utilization, medical care costs, and per capita spending escalate, there is growing debate about the value of these increases.

Certainly, medical care is important when one is ill and valuable even if it only alleviates pain. However, medical treatment does not always provide a cure. Table 4 illustrates the limits of medical intervention. Almost 21 percent of Medicare dollars in 1976 were spent for less than 8 percent of the elderly during their last year of life. In some instances, medical care can only provide temporary relief from suffering and does not offer a cure or prolong life, despite vast expenditures for the most sophisticated therapies.

TABLE 4. – Distribution of Medicare expenditures for persons who died in 1976

Age group	Percent of Medicare recipients who died in 1976	Percent of total Medicare dollars for each age group spent for recipients who died
All ages 65 and over	7.9	20.7
65-69	4.0	15.3
70-74	5.8	18.5
75-79	8.0	20.3
80-84	11.8	24.9
85 and over	19.8	32.1

Source: Charles R. fisher, "Differences by Age Groups in Health Care Spending," Health Care Financing Review, Vol.1, No. 4, Spring 1980.

Improvements in Health Status

The precise relationship between the use of medical care services—sophisticated technology, drugs, radiologic treatments—and health status is very complex and somewhat uncertain. A variety of factors influence health status—not only timely and appropriate use of the medical care system, but also greater acceptance of individual responsibility for lifestyle behaviors affecting health status. Recently, we have begun to recognize the critical role that lifestyle plays in promoting health and preventing disease. (For a more extensive discussion of the role of prevention see the last section of this chapter.)

The Challenge for the '80s

The demographic shift toward an older and relatively healthier population requires a reevaluation of health care delivery requirements. We must carefully target health and social welfare resources to meet the varied needs of an aging population. The realization of improved health status, as signaled by longer life expectancy for adults, has significant implications for the health care financing and delivery systems. Improvements in science's ability to identify health problems and develop solutions, whether therapeutic or behavioral, present a challenge for the Nation to apply medical care resources efficiently and to promote healthful lifestyles more effectively.

The Rapid Rise of Health Care Costs and the Reasons Behind It

The advent of the 1980s has witnessed no relief from the inflation in health care expenditures that has troubled health policy makers since the late 1960s. Although the health system has made many gains, inflation continues to be a serious problem and is now threatening to force major reductions that could reverse some of those gains. As discussed later, it is ironic that many of the successes of our health system are also contributors to the inflation problem.

The terms cost and inflation carry special meanings in the health system. In the broadest sense, cost refers to amounts that are spent, either by public or private health insurers or individuals out-of-pocket, for a health care "market basket" whose contents change over time. Thus inflation refers not only to increases in prices for a constant set of services, but also to increases in the complexity of services and the frequency with which they are used by consumers. In part, because use and complexity have increased as well as prices, inflation in health care costs has substantially exceeded that of most other sectors of the economy for decades.

TABLE 5. - National health expenditures and share of Gross National Product for selected years, 1965 to 1990

Year	Total expenditures (billions)	Percent public *	Percent of GNP
1965	$ 42.0	26.1	6.2
1970	$ 74.9	37.1	7.6
1975	$132.1	42.6	8.6
1979	$212.2	43.1	9.3
1985 +	$462.2	44.7	10.5
1990 +	$821.0	46.4	---

* Includes Federal, State, and local government expenditures.
+ Projected

Sources: Mark S. Freeland and Carol Ellen Schendler, "National Health Expenditures: Short-Term Outlook and Long-Term Projections," Health Care Financing Review, Vol. 2, No. 3 (Winter 1981), Table 4, p. 105; and National Indicators System. Report No. 7: Economics of Health Care. National Center for Health Statistics, October 1981.

The trend in national health expenditures, and future projections if effective remedial measures are not undertaken, is truly alarming. As illustrated in Table 5, national health expenditures were $42.0 billion in 1965, had reached $212.2 billion by 1979, and are projected to increase to $821.0 billion by 1990.[14] The share of Gross National Product devoted to health care was 6.2 percent in 1965 and had exceeded 9 percent by 1979. Projections indicate that this share will increase continuously throughout the 1980s.[15]

Table 6 presents distributions of the major components of health service expenditures and their trends since 1965. Hospital services have consistently consumed the largest share of the health care dollar, and this share has been growing in recent years — from 30 percent of the total in 1950 to 40 percent in 1980. Much smaller in size, but growing even faster, are expenditures for nursing home care (a service primarily used by the elderly) from 2 percent of the total in 1950 to 8 percent in 1980.[16]

TABLE 6. – National health expenditures by type of expenditure, 1950-1980, in percent

	Health care expenditures			
	1950	1960	1970	1980
All expenditures (in billions)	$13	$27	$75	$247
Type of expenditure (as percent of total)				
Hospital care	30	34	37	40
Professional services	32	32	28	28
Nursing home care	2	2	6	8
Drugs	14	14	11	8
Eyeglasses and appliances	4	3	3	2
Research and construction	8	6	7	5
Other services	10	9	8	9
Total	100	100	100	100

Source: National Indicators System, Report Number 7: Health Economics, National Center for Health Statistics, October 1981.

National health care expenditures are affected by a number of different trends and forces. The health care system is first affected by general inflation in the economy. The Congressional Budget Office, for example, reported that when hospital costs rose by an annual average of 15.0 percent from 1968 to 1978, roughly half of that increase, or 7.7 percent, was due to increases in the prices of the goods and services that hospitals buy.[17] The Department of Health and Human Services estimates that about 55 percent of the increase in per capita hospital expenditures between 1970 and 1980 was due to general inflation and that just over half of the rate of increase in total health care costs is due to the rate of increase in the Consumer Price Index. There remains, however, the question of the rest of the increase and why health care expenditures should be inflating nearly twice as fast as the rest of the economy.

Part of the answer is that the population is growing by about 0.9 percent per year. Even more important, the average age of the population is rising. Because health care costs are much higher for older people, on the order of two and one-half times as high for adults over age 65 than for those under age 65, this trend affects total expenditures.

One economist estimated, however, that only about 7 percent of the increase in per capita spending on health care between 1965 and 1978 could be attributed to aging alone.[18] While a growing and aging population is important, it does not account for a great deal of the increase.

One important factor is that health care services are not the same today as they were 20 or even 10 years ago. Some services didn't exist until relatively recent scientific breakthroughs made them possible. Total hip replacements were introduced in the last decade; cardiac pacemakers are now used by more than 250,000 people; complex open heart surgery requiring highly sophisticated equipment has become increasingly common. Over 70,000 people with kidney disease are able to receive dialysis services. Even routine hospital services have changed; there were 3.34 hospital employees per patient day in 1980 compared to only 2.65 in 1970 and 2.24 in 1965.[19] And an increasing percentage of hospital beds are equipped for intensive care.

Between 1970 and 1980, expenditures on hospital care per person increased three and a half times, and about 30 percent of that rise has been attributed to increases in service intensity.[20] Few would argue that these advances have not yielded benefits, for lives have been saved and the quality of life has been improved for many people. But they have added new products and services to the system and have increased the cost and nature of existing services.

There are a growing number of doctors in the country, the result of decisions in the 1960s to expand medical schools. The number of physicians per 100,000 population was 140 in 1960, grew to 174 by 1975, and has been projected to reach over 240 by 1990. A greater number of physicians is accompanied by higher expenditures.

Some economists claim that, unlike other markets where lower prices follow an increase in supply, when the supply of doctors, or at least of certain specialists, is greater, average fees are higher. Other economists find the evidence inconclusive. The dynamics behind all of this are not clearly understood and are actively debated. Nevertheless, as long as our current payment system remains unchanged, there is certainly little evidence to suggest that having more doctors will lower costs.

Finally, an important factor contributing to the rise in costs is the growth of third-party financing for health care services with its two primary payment mechanisms — fee-for-service for doctors and retrospective cost-reimbursement for hospitals. Each of these elements has had an important effect on how costs are perceived in the course of medical decisionmaking.

Third-party payers are organizations or programs that pay medical bills (patients and doctors are the first and second parties). The payers are commonly insurance companies or service plans such as Blue Cross or Blue Shield, but are also government programs such as Medicare or Medicaid, and can be employers who pay directly for services rendered to their employees. Recall the example described earlier: while the average cost of a hospital day rose from $15 to $245 between 1950 and 1980, the amount that the patient paid increased very little. After adjusting for inflation, the cost rose from $22 to $99 per day (in 1967 constant dollars), but the inflation-adjusted patient share rose only from $7 to $9 per day.

In part, this was deliberate. The Medicare and Medicaid programs and preferential tax treatment for employee health benefits were promoted largely to protect more patients from more costs. The figures above show that the strategy worked. But in protecting patients, third-party financing also conceals costs. It allows decisions to be made as if cost were no object, as if a hospital day really cost only 29 percent more in 1980 than in 1950 instead of over 450 percent more.

The first of the third-party payment mechanisms, retrospective cost-reimbursement for

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hospitals, weakens a hospital's incentives to find more efficient ways to operate. A hospital receives more revenue for providing more services or at least for having the capacity to provide more. Hospitals have every reason to offer the latest equipment and facilities to attract doctors and their patients. Their costs will generally be reimbursed even if the facilities are not used to full capacity.

Retrospective cost reimbursement necessarily involves many complex rules and regulations. Hospitals will be motivated to maximize their revenues subject to these rules, and to devote resources to trying to have the rules changed. But a hospital will not be motivated to improve efficiency, avoid adding new services that are already available elsewhere in the community, or discourage excessive use of its laboratory or other services. Cost-reimbursement fundamentally encourages the growth of costs and is a major contributor to the increases in service intensity cited above.

Similarly, fee-for-service payment to physicians means physicians earn more when they perform more services or choose the more costly alternative when a choice of procedures is available. There are of course other considerations equally important or more important to a physician — concern for the patient and a sincere wish to do the best thing, respect for professional standards, a desire for professional excellence, and the esteem of peers. Physicians do not render services solely for fees. The weight of the economic incentives of fee-for-service financing, however, is inevitably on the side of generating more costs.

In summary, health care costs have grown for many reasons. General inflation, the growing and aging population, technological advances, increasing intensity in routine services, a greater number of physicians, rising expectations, and growing incomes have all contributed. At the same time, we have seen rapid expansion of the financing system that encourages the growth of costs while concealing those costs from doctors and patients. Developed originally to protect patients and remove financial barriers to needed care, the financing system and the incentives it creates has itself become part of the cost problem.

Why Incentives Are Important

The idea that economic incentives play an important role in medical decisions is one that many people at first reject. If the point of expanding insurance coverage was to remove economic considerations from medical care decisions and permit those decisions to be made on the basis of medical needs in each case, how can problems be worse now that insurance coverage has expanded?

Underlying this view are some basic misconceptions about medical care and the nature of economic incentives. First, there are always economic incentives whenever there are economic transactions. They may not be the only factors or even the most important factors in decisions, but a provider of services always knows what will produce more revenue and what will produce less. Any individual or organization that consistently acts against its own interests and loses money will not survive.

If there were always clear-cut "right" or "best" services to be rendered in matters as important as saving lives and restoring health, it would not be inappropriate to think simply of making sure resources were available to pay for those services. We would not worry about economic incentives because humanitarian concerns would dominate. Furthermore, there are many instances when medical care is like that, when there is agreement on what to do for a patient and consensus that good results can be expected. There is nothing economically wrong with assuring everyone access to this kind of care.

But there are also many examples of cases when medical care does not fit this model. As medical science has evolved, some procedures and practices that were once viewed as vital have, after systematic evaluation, been rejected as not effective or replaced by new alternatives. Even more important, medicine is characterized by a great deal of uncertainty. A doctor often faces major uncertainty about what is wrong with a patient. There is uncertainty

about whether or not tests will be able to provide answers, about how reliable various tests are, about whether more tests would help. There is uncertainty about the causes and effects of many diseases, and there is uncertainty about treatments.

Frequently, there may be more than one legitimate alternative for managing a particular medical condition. Individual needs, preferences, lifestyles, and values vary. The same treatment that might be acceptable to someone who lives with a family might make it impossible for someone living alone to remain independent. Different treatments can have different risks and probabilities of success associated with them. In these cases, the values of the patient and the judgment of both the doctor and the patient are important.

In the countless instances where both uncertainty and multiple legitimate options exist, the economic incentives in today's financing systems become more important. They do not necessarily override humanitarian and professional concerns, but when it is genuinely unclear what is the best course of action, doctors and patients, when they need not consider costs, will tend to resolve uncertainty and exercise judgment on the side of doing more.

Ideally, doctors and patients would balance cost considerations with other considerations. Is the information we can reasonably expect to get from another test really worth the extra cost? Does an extra day in the hospital offer enough to be worth the cost, or would the patient actually be better off at home with the family? Will another specialist's opinion really provide valuable new information? For a patient, does a particular problem really warrant the cost of a visit to the doctor or to a specialist rather than an internist? When we do as we have done and remove cost from decisionmaking, however, these questions are rarely asked. And when we actually reward providers by paying them more when they opt for doing more while protecting their patients from having to share the costs, we must expect the kind of inflation we have seen.

There is evidence that different economic incentives do produce very different cost results, and they do so without compromising the quality of care. This evidence is discussed in more detail in the next section. Experiments with various patient coinsurance arrangements have shown total per capita costs reduced by up to 30 percent. Health maintenance organizations (HMOs), with different incentives for their participating providers, reduce the number of hospital days per thousand Medicare enrollees by 30 percent. Results like these, combined with the above insights into the nature of medical care, lead analysts to examine carefully the incentives created by policy alternatives and to seek to balance the goal of protecting patients from high medical costs with the goal of creating appropriate incentives.

HEALTH POLICY AT THE CROSSROADS: Regulation and Competition

Leading experts agree that the health care financing system creates perverse economic incentives that contribute to the rapid increase in health care costs. Most also agree that unless something is done to alter or counteract those incentives, costs will begin to rise still faster as medical researchers develop ever more sophisticated technology and the average age of the population increases.

The consensus begins to disintegrate, however, when the discussion turns to how to make the system more efficient. Some analysts contend that public policy must accept the existing financing and delivery arrangements as immutable, however inflationary they might be. In this view, consumers and providers have become so accustomed to these arrangements that only marginal changes will occur for the forseeable future. As a result, this school argues that

government must cap the resulting inflationary pressures through regulatory controls on health care providers.

Other analysts reject the view that the existing ways of financing and delivering health care are immutable. While conceding that change may be slow and occasionally discomforting for consumers and providers, these analysts believe that gradually people will respond to rising costs by changing how they buy their health care—for example, by enrolling in health plans with higher deductibles and coinsurance or enrolling in HMOs or other alternative delivery systems that include effective restraints on cost increases. These competition advocates believe that government's role is to hasten this natural evolution through strategically placed incentives and by removing barriers to competition. Any effort by government to ration medical care through regulation is viewed as at best futile and at worst destructive.

Through the mid-1970s, the proponents of regulation had far more influence on public policy. Pursuant to the National Health Planning and Resources Development Act of 1974, virtually all States enacted certificate-of-need statutes designed to curb unnecessary capital investment in hospitals. Following the lead of the Nixon Administration's Economic Stabilization Program (ESP), which imposed direct controls on hospital rates from 1972 through 1974, eight States also instituted mandatory hospital ratesetting programs.

The results of these efforts were mixed. Most systematic statistical analyses of certificate-of-need regulation have concluded that nationwide it has not restrained per diem, per case, or per capita hospital costs.[21] Some studies have concluded that certificate-of-need regulation may even increase hospital costs by skewing patterns of investment away from regulated capital inputs and toward unregulated labor, even where capital inputs are more efficient.[22] The success of certificate-of-need controls does not seem to vary appreciably with the age of the program or other variables that lend themselves to statistical analysis,[23] although there may be nonquantifiable circumstances that cause it to have some effect in a few States.

The findings on hospital ratesetting have been somewhat more encouraging for the proponents of regulation. While there is disagreement, at least some analysts have concluded that the Economic Stabilization Program (ESP) had a slight moderating effect on inflation. However, even some of the analysts who conclude that ESP had an effect doubt whether the benefits would have lasted if the program had remained in place.[24]

Descriptive evidence on State ratesetting programs suggests that increases in expense per admission, expense per patient-day, and total expenses were lower in 1977 and 1978 in States with ratesetting than in other States. In the eight ratesetting States, total hospital costs increased 9.7 percent in 1976–1977 and 8.6 percent in 1977–1978, while costs were rising 15.8 percent and 14.0 percent in the other States and the District of Columbia.[25]

More rigorous statistical analyses have also found a cost-reducing effect from State ratesetting. For example, the Congressional Budget Office found that State ratesetting reduced per capita hospital expenditures by about 3 percentage points between 1976 and 1978,[26] while Sloan concluded that well-established ratesetting programs that apply to all payers, public and private, may reduce hospital costs per admission and per day by up to 20 percent.[27] Sloan detected no effect on costs from new ratesetting programs.

Despite this evidence, critics of regulation have questioned whether hospital ratesetting is an acceptable, reliable long-term approach to slowing the rise in health care costs. Some critics observe that the most successful State ratesetting commissions cap hospital budgets without addressing why those budgets have been increasing. They say the primary cause of the increase has not been hospital waste but rather increasing physician and patient demands for more costly services—demands encouraged by a financing system that removes any reason for physicians and patients to be concerned about costs. The effect of hospital ratesetting, in this view, is to squeeze the hospital between the unyielding demands of its customers and the unyielding demands of its regulators. The result is artificially low hospital rate ceilings that drive hospitals to the brink of bankruptcy. Eventually, these critics conclude, ratesetting will undermine the

quality of care or ratesetters will succumb to political pressure, allowing hospitals to recoup their losses.

The lesson that competition advocates draw from the experience with regulation is that regulation has failed because it has not addressed the root cause of the health cost spiral: escalating demand for physician and hospital services, stimulated in large part by the financing system. Competition advocates would address that problem in three ways: by increasing the economic incentive for workers to enroll in health plans that are effective in controlling costs; by giving Medicare and Medicaid beneficiaries the option of using their benefits to enroll in efficient private plans; and by reforming the ways the public programs pay providers.

To encourage workers to enroll in more efficient health plans, the proponents of competition would change the tax treatment of employer-paid health benefits. As discussed earlier, the current tax law does not include employer payments for health insurance in the employee's taxable income, in effect subsidizing the purchase of insurance. Proponents of competition contend that this subsidy causes workers to buy more health care coverage and different types of coverage than they otherwise would. Specifically, it is argued that the effect of the large tax subsidy is to make workers less inclined to enroll in health plans with large deductibles and coinsurance or in HMOs that limit the worker's free choice of physician.

Among the options for limiting or offsetting the ill effects of this tax subsidy are: repealing the tax exclusion for employer-paid benefits, making all employer contributions taxable; imposing a dollar limit on the maximum tax-free contribution; or giving workers a "tax neutral" choice between cash and health benefits by offering workers tax-free cash rebates if they enroll in a low cost health plan.

There is limited empirical evidence bearing on how these proposals would affect consumer behavior, but what evidence exists seems to confirm that the demand for insurance is sensitive to price. The premium of an insurance plan consists of an amount to cover expected benefit payments plus an amount, known as the loading charge, to cover costs such as marketing and administration. A study by Phelps found that when this loading charge increases 10 percent, the proportion of medical bills paid by insurance decreases 6 to 8 percent.[28] Goldstein and Pauly obtained generally consistent results in a separate study.[29] Having reviewed this literature, Paul Ginsburg of the Congressional Budget Office concluded that eliminating the preferential tax treatment of insurance would cause workers to increase the deductibles and copayments in their insurance policies, and this is why he estimated the proportion of expenses covered by insurance would be reduced by up to 25 percent.[30]

The second major component of the competition strategy is to offer Medicare and Medicaid beneficiaries the option of using their benefits to enroll in a private health plan. For example, Medicare would offer each beneficiary a voucher that he could use to pay the premium of an HMO or insurance plan meeting specified minimum standards. The voucher would be worth the same amount that it would cost Medicare to care for that beneficiary for a year. If the premium of the private health plan were lower than the value of the voucher, the beneficiary would be entitled to a cash rebate equal to the difference. If the plan's premium were higher, the beneficiary would have to make up the difference out of his own pocket. In any case, all beneficiaries would be entitled to remain in Medicare if they desired.

There is little empirical evidence on how Medicare beneficiaries would respond to this option. Much would depend on the amount of the voucher and the private plans available in a given market. In at least one experiment, however, an HMO has been able to stretch the voucher offered by Medicare to cover not only the basic Medicare benefits but also to eliminate the deductibles and coinsurance now charged to Medicare beneficiaries and to cover new benefits not covered by Medicare, such as routine physical examinations, examinations for hearing and vision, and most immunizations. In other words, for the amount of the voucher, this plan is able to offer coverage that improves on what Medicare can offer even when combined with a Medigap plan. Where health plans are able to lower the cost of basic

Medicare benefits to offer such expanded coverage, the new option is likely to appeal to many beneficiaries. How many plans will replicate this experience is unclear.

If in fact many workers and public program beneficiaries responded to a change in the tax treatment of employer-paid health benefits or Medicare (or Medicaid) vouchers by enrolling in insurance plans with more patient cost-sharing or in HMOs, it would lower health care costs. For example, competition advocates cite the Rand Health Insurance Experiment, which randomly assigned people to health plans with different levels of cost-sharing. Among other things, the Rand experiment found that individuals enrolled in a plan with $1,000 deductible had health care expenses 31 percent lower than those enrolled in a plan that paid all bills in full. Enrollees in a plan with 25 percent coinsurance on all services (until an income-related catastrophic limit was reached) had expenses 19 percent lower than those enrolled in a plan without any cost-sharing.[3]

Critics of the Rand experiment make two basic points. First, they point out that there are as yet no data on the health status of enrollees in the cost-sharing plans—that is, we do not know whether enrollees saving on out-of-pocket payments inadvertently cut needed medical services to the detriment of their health. Second, the critics contend that cost-sharing is already being exploited as a cost containment strategy. In their view, the typical insurance policy is less like the Rand experiment's comprehensive plan with no patient cost-sharing than the 25 percent coinsurance plan. As a result, even if people were to switch to a plan with a $1,000 deductible, most would experience not a 31 percent drop in expenditures but only a 15 percent drop.

There are as yet no experimental data on the performance of HMOs but Luft's survey of the HMO literature found evidence that HMOs reduce health care costs by 10-40 percent, depending on the plan.[32] Nearly all of this reduction is attributable to lower hospitalization rates.

Like the critics of patient cost-sharing, HMO critics raise the specter that HMOs cut costs by cutting the quality of care. However, little reliable evidence has been offered to support this assertion. At most, the evidence is anecdotal and limited to isolated plans.

HMO critics have also alleged that HMOs have lower costs and utilization rates not because they are efficient but because they enroll healthier people. It is argued that less healthy individuals generally do not enroll in HMOs because often they would be required to sever their relationship with their current physician. Again the evidence is ambiguous, and it is inappropriate to generalize about all HMOs. As a rule, older and larger HMOs are more likely to have a representative selection of risks. For example, a study by Blumberg suggests that the large HMOs in California may even have a worse than average selection of risks yet still are able to reduce costs.[33]

The third type of reform endorsed by competition advocates is reform of the Medicare and Medicaid reimbursement of hospitals. As yet there is no consensus on specific changes, but there is agreement that the new system should break with the existing principle of retrospective, cost-based reimbursement. In other words, Medicare and Medicaid should not simply reimburse hospitals for whatever costs they have incurred but rather pay hospitals what it should cost to care for a particular patient. If in fact it cost the hospital more than this prospectively determined amount, the hospital would lose money; if the hospital could provide the necessary care for less than the government payment, it would earn a profit.

Support for these principles can be found in all ideological camps and even in the hospital community. The dissent appears when specific proposals are made to implement the principles. A specific proposal necessarily would result in some hospitals coming out ahead while others would be worse off than under current law. In addition, many of the options pose significant administrative problems.

Conclusion

The health policy debate is often cast as a choice between regulation or competition. What is often neglected is that in a Federal system there is ample opportunity to apply both tools and

to combine them in myriad ways.

If the Federal Government were to withdraw from cost-containment regulation, each State would be free to experiment with certificate-of-need regulation and hospital ratesetting. At the same time, the Federal Government could act to neutralize the inappropriate incentives built into the tax code and open up the public programs to competition among private health plans. States that strongly believed in competition would withdraw entirely from certificate-of-need and ratesetting. Yet States that favor regulation would not be adversely affected by the procompetitive tax changes and voucher programs; on the contrary, these steps would complement the State regulatory programs. Rather than having to battle to make provider controls effective in the face of burgeoning demand, these steps would mean that regulators would see a decline in the demand for hospital care.

Although it is not essential that the Nation choose once and for all between competition and regulation, it is essential that it begin the long process of winding down health care inflation. Whether one favors regulation or competition, it is becoming ever clearer that the status quo is untenable.

LONG-TERM CARE

Long-term care refers to the support services needed by persons who have functional limitations resulting from or in conjuction with chronic illness or other conditions that make them frail and dependent. It is an area of particular concern to the elderly.

There is widespread agreement that a long-term care system should promote the independence of the person in making decisions and in performing everyday activities. It should encourage support services in the least restrictive environment, preferably at home or in other community settings. It should try to make available appropriate, cost-effective, accessible, and humane care to all persons who need it while supporting the care provided by family and friends. For chronically impaired individuals who must receive care in nursing homes and institutional settings, it should ensure the quality of their care and seek to maximize their quality of life. Finally, public policy for long-term care should make maximum use of family, community, and other private sector initiatives to achieve these objectives.

There is also growing awareness among family members, the general public, government officials, and professional service providers that there are problems in achieving these goals.

The People

Approximately 6 million people are in the long-term care population because they need help in mobility or personal care. This is approximately 2.6 percent of the Nation's population. Fifty percent of people who require assistance in eating or going to the bathroom are in nursing homes but only 5.3 percent of the disabled population need this kind of help. Only 2 percent of those dependent in mobility are in nursing homes.

The overwhelming majority of the elderly are healthy. While it is true that approximately 15 percent may need some form of assistance in personal care or mobility, outside or inside the home, in many cases the level or extent of help needed is minor. Of the approximately 15 percent of the elderly who need some help, 7.1 percent need help outside the house or neighborhood; 0.8 percent need help inside the house, and 6.2 percent need help bathing and/or dressing. Of the total population of elderly and disabled persons, a full 75.9 percent can be cared for within the community. Only 24.1 percent are institutionalized in nursing homes at any point in their lives. Of those persons who do not need assistance for personal care or mobility, less than one percent (0.6 percent) are institutionalized in nursing homes.

It is also true that the elderly population will continue to expand. Furthermore, projected growth rates are greatest among those over 85 who are most likely to become frail. According to the Series II Census projections, the population aged 65 and over is expected to increase by 26 percent between 1980 and 1999. The rate of increase among those 85 and over, however,

will be twice that: in 1999, there will be 1.4 million more very old people than there are today.

Those needing long-term care tend to have lower incomes. In 1977, 41 percent of all the noninstitutionalized functionally disabled had incomes less than $6,000; 46 percent of the noninstitutionalized functionally disabled age 65 and older had incomes less than $6,000. By comparison, only 16 percent of all individuals and 39 percent of all elderly were this poor. People who have insufficient financial resources to purchase adequate services, and whose family and friends are unable to help, find it difficult to maintain an independent existence in the community. Although most of the disabled live with others who can help them, some 20 percent live alone and therefore must make arrangements to secure services, which may only be available in institutional settings.

The Programs

Long-term care needs are financed by a variety of Federal, State, local, and private programs and expenditures. The principal Federal programs that provide resources for long-term care needs are Medicaid, Medicare, the Social Services Block Grant, Supplemental

TABLE 7 – Expenditures for selected Federal programs, fiscal year 1978 (in millions of dollars)

	Medicare[1]	Medicaid[1]	Old Age Survivors[2]	Disability Insurance[2]	Supplemental Security Income[2]	Social Services Block Grant[3]	Older Americans Act[4]	Veterans Administration[1]
Income maintenance			$53,25[illegible]	$10,315	$6,552			
Basic living services								
Transportation						$ 71	$ 19	
Housing						$ 28	$ 3	
Meals						$ 22	$247	
Chore services (Homemaker/health aide)						$481	$ 17	
Dependency services								
Day care						$ 34	$ 2	
Home health	$ 548	$ 160				$ 98		
Illness/disability services								
Nursing home care	$ 396	$ 7,246						$ 281
Physician services	$ 5,548	$ 2,054						$ 57
Hospital services	$18,275	$ 6,854						$4,141
Total	$24,767	$16,314	$53,255	$10,515	$6,552	$734	$288	$4,479

1 Gibson, Robert, "National Health Expenditures, 1978, *Health Care Financing Review*, Summer, 1979, (1-36).

2 Social Security Administration, the Social Security Bulletin – Annual Statistical Supplement, 1977-79. Figures shown are for calendar year, 1978.

Dollar payments for the Old Age Survivors and Disability Insurance programs shown are for retired and disabled workers only. Figures for dependents and survivors have not been included.

3 Planned expenditures rather than actual spending, obtained from State Title XX plans. *Technical Notes, Summaries and Characteristics of States' Title XX Social Services: Plans for Fiscal Year 1979*, Gloria Kilgore and Gabriel Solman, Washington: DHEW/ASPE, June 15, 1979.

4 AOA program statistics

Security Income, Title III of the Older Americans Act, Veterans Administration programs for disabled veterans and their families, and HUD housing construction and assistance programs. Table 7 summarizes Federal spending in fiscal year 1978 in the major programs that support individuals who need long-term care.

According to Table 7, the bulk of Federal dollars in these programs were spent on basic income support and acute care health needs (hospitals and physicians). Of the dollars spent specifically on long-term care services, the lion's share is spent in Medicaid on nursing home care. In 1978, Medicaid alone financed approximately 50 percent of the total national nursing home bill. Private financing accounted for 42 percent of the remainder. Medicare pays a relatively small amount of the Nation's nursing home bill, primarily for posthospital recuperative care. Both Medicare and Medicaid fund a relatively small number of home health care and in-home services. The social services block grant and Title III of the Older Americans Act give States flexibility to spend appropriated funds on a wide variety of support services ranging from chore services to day care to respite care to "meals on wheels" and nutritional services.

The relative amounts available for these services are small, however. Most recently, Section 2176 of the Omnibus Reconciliation Act of 1981 gives States the flexibility to apply for waivers to fund a wide variety of home and community care services under Medicaid. States can supplement Federal Supplemental Security Income payments to provide medical care to individuals. Several but not all States do so. The Veterans Administration provides a wide variety of benefits to veterans and their families ranging from home and attendant care allowances to nursing home services.

In addition to these major programs, there are a variety of State, local, county, and private activities in long-term care. The relative share of total long-term care expenditures financed by each is difficult to estimate, and cost figures are available only for nursing home care. However, it is estimated that 60-80 percent of all long-term care needs, other than nursing home care, are met informally by family and friends.

Federal reimbursement for State vendor payments to skilled nursing homes began under Kerr-Mills in 1960, continued under Medicaid which superseded Kerr-Mills in 1965 and was then expanded to Intermediate Care Facilities in 1972. On the other hand, Medicare (also enacted in 1965) has never expanded nursing home coverage beyond skilled nursing facilities. The nursing home and home health benefits in that program have remained primarily posthospital acute care benefits.

Expenditures under the Social Services provisions of the Social Security Act (Title IV(a)) were authorized in 1962 but grew slowly until the late 1960s and early 70s when their rapid growth forced Congress to cap them at a level of approximately $2.5 billion a year. Title IV (a) became Title II in 1975 and the long-term care share of the program has run around $600 to $700 million in recent years. In 1981, it was converted to the Social Services Block Grant. The Older Americans Act, passed in 1965, gave State and area agencies broad discretion in making expenditures. Like the Social Services Block Grant, only a relatively small proportion is spent on the long-term care needs of elderly citizens.

THE PROBLEMS

Fragmentation of the Long-Term Care Delivery System

Long-term care requires a wide range of services by the family, community, private organizations, and government. The service delivery system is highly diversified in both sources of financing and delivery of services. Diversity at the local level can be beneficial, for it permits local communities to tailor the services to their particular needs. However,

diversity at the Federal and State levels may lead to unnecessary duplication, administrative burden, and expense. The Department of Health and Human Services alone has 27 programs that provide resources for people with long-term needs. This multiplicity of Federal programs and agencies is mirrored at the State and local level. These various government programs have different eligibility requirements, benefit coverage regulations, administrative structures, and methods of providing services.

The result is a complicated and confusing system in which individuals and their families may experience difficulty in locating and using the most appropriate services. Moreover, incentives are created for a doctor or social worker to institutionalize a person rather than try to piece together the complex array of services from different programs necessary to permit someone to remain in the community. The 1981 White House Conference delegates clearly favored greater efforts to decrease institutionalization.

Insufficient Alternative Settings and the Mismatch Between Needs and Available Services

Evidence from some national surveys suggests that there is a substantial group of people with a wide spectrum of functional limitations who receive appropriate care in a variety of settings. Rather extensive evidence, however, also indicates that some people are getting services in settings that foster dependency when they might be able to receive them in less restrictive settings, were there not financial and systematic barriers. Estimates of inappropriate placement based on various criteria range between 10 percent and 40 percent.[34] For example, a significant proportion of nursing home clients are functionally dependent in relatively few areas and do not require the full range of services available on a 24-hour basis in nursing homes. Some could be cared for outside of nursing homes if there were more services available in a greater variety of settings. Services provided within nursing homes could be better matched to patient needs if reimbursement systems under Medicare and Medicaid were appropriately reformed.

The choice is not simply between institutional care and in-home services provided in widely scattered living sites. While providing some services in alternative settings may be more costly than the same services provided in nursing homes, it is likely that some services can be provided cost-effectively to people living in other group settings: apartment complexes for the elderly, congregate housing, and the like. Further, some services may be provided in collective settings on an intermittent basis to people who usually live in independent households (e.g., respite care, adult day care).

Inadequate Support for Informal Support Mechanisms and Community Care

Most long-term care services are provided by families and friends. Research increasingly points to the important role informal support networks play in preventing premature institutionalization or reliance on costly formal service systems. Also, recent studies suggest that the success of formal home-based services depends on the availability and willingness of friends and family to provide additional services.

Current Federal policies do not explicitly acknowledge the contribution of the informal support system and often work against it. Assets and income policies in Medicaid and SSI do not reflect a consistent view of the role that spouse and family can and should play.

In part, the reluctance to expand Federal support of community-based services is due to a fear that such formal programs will substitute for informal programs and hence add immeasurably to the public burden. However, far too little attention has been given to the current incentives for substituting formal institutional care for informal care. Public programs will pay for all living and personal care services in a nursing home, but there is little public subsidy of services in private homes that might enhance the ability of family and friends to meet the bulk of care needs.

Medicaid encourages institutional care for several reasons. First, until the recent enactment of home and community care waivers, Medicaid permitted States to allow individuals with higher incomes to become eligible in the institutional setting but not at home. Second, States often fail to cover optional in-home services in their programs while nursing homes are covered in all States. Third, the high cost of nursing home care exhausts individual assets more rapidly and makes individuals eligible for Medicaid coverage sooner under the provisions of State medically needy programs. Fourth, Medicaid will pay for basic living expenses such as room and board only in nursing homes, giving low-income individuals financial incentives to be in nursing homes where these costs are covered.

The Costs of Long-Term Care

The costs of long-term care services have been increasing more rapidly than health care costs in general. For example, the costs for nursing home care are estimated at $17.8 billion in 1979, an increase of 76.2 percent over 1976 compared to a general medical inflation rate of 42.2 percent over the sam period. Costs for personal care services and related long-term care services are also increasing rapidly.

Rapid inflation in the long-term care sector creates several specific problems, the most obvious of which is that rapidly increasing costs increase the rates at which individuals exhaust private resources. This hastens the day they must seek public assistance.

Because of rapidly escalating costs it is difficult for people to plan for a secure retirement given the possibility of large potential costs for nursing home care or for personal care services. Available data indicate that although nursing home care costs per resident were approximately $8,000 in 1975, average per capita income for those over 65 was only $5,349. While the majority of nursing home patients initially use private funds, a substantial proportion convert to public sources of payment after exhausting personal resources. Private resources are, on average, depleted within the first year of entering a nursing home.

The long-term care component of Medicaid spending is a particularly important policy consideration. In 1980, across all the States some 9 percent of beneficiaries using long-term care accounted for a full 47 percent of total Medicaid expenditures.

The Agenda For The '80s

In order to deal with the above problems, a cooperative effort between the Federal Departments, the Congress, all levels of government, and the private sector is necessary. A wide variety of private sector activities are already underway. These include the development of continuing care communities, reverse annuity mortgages, private long-term care insurance, and increased employer provision of disability benefits. There are also proposals for the construction of alternative housing, increased community use of volunteers, and the expansion of hospitals and nursing homes outward along the care continuum into community-based services.

Government can act through a variety of tax incentives, loan guarantees, and other mechanisms to support private activities that will ensure adequate alternatives to institutional placement and increase the range of choices available to individuals. A variety of mechanisms, including tax credits for the care of dependent family members, vouchers, and direct payments to family members deserve exploration. If private sector provision and individual savings for long-term care needs are maximized, the residual public sector burden can be minimized and scarce public resources can be concentrated on those who are poor or who have no family left to help provide care.

Public policy needs first to identify and then target limited resources to those who, without additional help, would enter institutions largely at public expense. In addition, emphasis needs to be placed on biomedical research and preventive approaches that

can help ameliorate the projections of future long-term care needs. It has been estimated, for example, that a cure for senile dementia could reduce the future need for nursing home beds by as much as 50 percent.[35] However, increased emphasis on upgrading physicians' knowledge of geriatrics and increasing the access of the elderly to skilled professionals trained in gerontology can help reduce rates of decline among the elderly and raise the average age of institutionalization. Finally, the delivery system for long-term care services needs to be rationalized so it can operate in a manner that ensures maximum continuity of care and maximum efficiency in the provision of services, and encourages providers, consumers, and government to play their appropriate roles.

PREVENTIVE MEDICINE AND HEALTH PROMOTION

Investments in disease prevention and health promotion are among the most effective and efficient that could be made to improve the Nation's health. Indeed, the concept has been a cornerstone of classic public health activities, and the success of these traditional forms of public health has been dramatic.

At the turn of the century, diseases such as tuberculosis, rheumatic fever, smallpox, diphtheria, and tetanus were among the primary causes of death. Eight decades later, none of these infectious diseases is any longer a major cause of death and disability in the United States.[36] Examples of public health efforts that were instrumental in virtually eliminating infectious diseases as the major source of death and disability in this Nation include pasteurization of milk to interrupt the spread of tuberculosis, infrastructure development, including public water and sewer facilities; and more recently, fluoridation of many public water supplies and immunization against preventable diseases.

As a result of the success of interventions to halt infectious diseases, the health problem currently faced by the Nation is chronic disease.

> Arteriosclerosis, ... arthritis, adult-onset diabetes, chronic obstructive pulmonary disease (including emphysema), cancer, and cirrhosis represent the overwhelming majority of our health problems. They are widespread conditions that originate in early life and develop insidiously; the probability of their occurrence increases with age . . . Generally, they develop slowly and asymptomatically below a clinical threshold, at which [point] the process becomes clinically evident, progresses, and often culminates in death or disability.[37]

As much as 80 percent of deaths currently are the result of chronic illness and disease; the effect on disability may be even more substantial.[38] Public health practices that have worked for control of infectious disease too often may be inappropriate for or irrelevant to the problem of chronic disease.

In analyzing current disease prevention and health promotion alternatives it is useful to separate alternatives within the so-called medical model from those that are essentially within the individual's control, having to do with lifestyle.

Disease Prevention

Prevention activities are a long-term investment. One way to value disease prevention and health promotion is the willingness of people to pay for it. When an individual chooses to make an investment in his own health future, and pays the costs himself, the decision regarding cost-effectiveness is the purchaser's alone. When others are asked to pay, they are entitled to ask whether the benefits to them outweigh the costs. One reason why so few

third-party insurers pay for preventive services is that many of the benefits — primarily cost savings — that may eventually accrue are long-term, while the costs are immediate or short-run. Because there are likely to be changes in the beneficiary's employment, carrier, or coverage over time, the results of today's prevention expenditure do not often benefit today's private third party payer.

The Surgeon General defines disease prevention as beginning with a threat to health.[39] It seeks to protect as many people as possible from the harmful consequences of that threat. Disease prevention, then, consists of a minimum set of activities within the medical model, differentiated primarily by age and sex, whose efficacy is generally accepted within the medical profession.[40]

That there is substantial popular interest in and desire for medically-oriented prevention is demonstrated by the 1975 National Ambulatory Care Survey. The survey found that the most frequent reason for patient visits to internists — accounting for 3.5 million visits that year — was for well-patient physical exams. However, there may be a substantial gap between that popular interest and the demonstrated efficacy of certain medical prevention-oriented screening services, especially for the elderly. For example:

> An in-depth review of the medical evidence for seeking 78 different medical conditions during a periodic health examination . . . concluded the evidence was so poor for 36% of the conditions that decisions could not be made scientifically. For only 21% of conditions (mostly infectious diseases) was the treatment or prevention supported by evidence from well-conducted, randomized, controlled trials.[41]

Another example examined not only efficacy but also cost-effectiveness. In the now classic Kaiser-Permanente study — one of few methodologically excellent cost-benefit examinations of prevention — only for men aged 45-54 did the preventive Multiphasic Health Checkup show a net cost savings.[42] The study showed no savings for women or other age groups of men.

Clearly, childhood and many adult immunizations have a significant positive benefit-to-cost ratio. Death from influenza is 10 times more likely for those over 75 than for the population aged 55 to 64. Those suffering from various chronic illnesses and diseases are at an even higher risk from influenza. Similarly, the death rate from pneumococcal pneumonia is 10 times higher for those over 75 than for the general population; it is more than twice as high for those aged 65 to 74. The medical efficacy of vaccinations for these diseases is established; continuing research can be expected to improve their cost-effectiveness.

Recent work by the Congressional Office of Technology Assessment indicates positive benefit/cost ratios for Pap smears. Mammography and other forms of breast examination are medically efficacious for women in mid to late life. Carefully targeted hypertension screening and control also seem to be cost-effective, as is fluoridation.[43]

Scientifically acceptable documentation of the efficacy, let alone cost-effectiveness, for many other medical prevention interventions, however, is still not available. Rather, evidence is accumulating that actions outside of the medical model of prevention but within the individual's control may determine whether or when various chronic diseases occur.

> . . . Chronic diseases are approached most effectively with a strategy of 'postponement' rather than cure. If the rate of progression [of chronic diseases] is . . . sufficiently postponed, the symptomatic threshold may not be crossed during a lifetime, and the disease is 'prevented'.
>
> Some chronic illnesses definitely can be postponed; elimination of cigarette smoking greatly delays the date of onset of emphysema and reduces the probability of lung cancer . . . In other illnesses, circumstantial evidence of similar effects of postponement is strong but proof is difficult: that arteriosclerosis is retarded by weight reduction or exercise is suggested by associative data but has not yet been proved.[44]

Health Promotion

The Surgeon General's Report defines health promotion as beginning with persons who are basically healthy and seeking to develop measures that can help them initiate and support behaviors that maintain and enhance their well-being.[45] The goal of health promotion, then, is to induce individuals (and society) to do what is in their own illness-preventing best interest.

The focus here is lifestyle modification. Study has indicated that making appropriate changes in personal behavior or lifestyle with regard to drinking and smoking, diet, sleep and exercise, wearing automobile seat belts, and observing speed laws can extend life by as much as 11 years over those who practice undesirable behaviors in these areas.[46]

As with prevention, so too in too many promotion areas, our knowledge of what works, for whom, and why, is woefully inadequate. This is particularly true with regard to how to induce appropriate individual behavior, such as smoking cessation. However, there is substantial suggestive evidence that people, on average, will act to change their behavior as the evidence of ill effects becomes increasingly better known. Some examples:

- Between 1964 and 1975, there was a 26 percent reduction in the number of males who smoke, and an 8 percent reduction among women; the result has been a 22 percent reduction in per capita consumption of tobacco.
- For the period 1963-1975, per capita consumption of fluid milk and cream fell 20 percent, butter 32 percent, and eggs 13 percent. The percentage of the population with high cholesterol was also significantly reduced: for males aged 45-54 down 6 percent, aged 55-64 down 14 percent; for females aged 45-54 down 13 percent, aged 55-64 down 29 percent.
- Untreated hypertensives in the Nation fell 10 percent over the 1962-1974 period.

These factors have all been components in the decline in U.S. deaths due to heart disease, which fell by 22 percent between 1968 and 1977. On the other hand, some 80 percent of Americans do not use seatbelts despite their simplicity, constant availability, and proven effectiveness in reducing morbidity and mortality.[47]

These observations collectively indicate three things. First, individuals have a broad interest in maintaining health. Second, and closely related, at least some forms of disease prevention and health promotion efforts apparently have the power to change behavior. Third, they indicate that additional research needs to be done, not only to determine what disease prevention and health promotion activities work and are cost-effective, but also how to bring that knowledge in an effective way to the public as well as providers of health care.

The Surgeon General's Report quotes a 1976 analysis of the 10 leading causes of death that indicated that at least 50 percent of mortality was likely due to unhealthy behavior or lifestyle. Twenty percent was due to environmental factors, 20 percent to human biological factors such as genetics, and only 10 percent was due to inadequacies in medical care.[48] Even when taken only as indicating orders of magnitude, these figures suggest that major future improvements in the health status of the population are most likely to be made through prevention of disease and promotion of good health, not through acute care and treatment.

What Is Possible For The Elderly?

As the prior examples and dicussion indicate, health promotion's usual messages need to be understood, accepted, and acted upon as early as possible during an individual's life. On

average, most chronic diseases can only be successfully avoided or, at least, maximally delayed if preventive practices and lifestyle modifications are followed over the long term. Nevertheless, while good data on health consequences are lacking, such behavioral changes as smoking cessation, proper exercise and nutrition, weight control, proper rest, and use of seat belts can still prove useful to health whenever they are adopted.

Beyond these activities, however, several other measures seem particularly useful with regard to quality of life for the elderly. An increasing literature, derived from the realms of both health and social services, suggests the need and desirability of support against social isolation and loneliness. Prevention includes mechanisms as diverse as the extended family and the availability of appropriate recreational and congregate meeting facilities for the elderly,[49] the latter within the provenance of voluntary or service organizations, local governmental bodies, and even home health or nursing facilities that serve the aged.

Because the elderly receive frequent medications to meet their chronic and acute medical needs, providers should know what other drugs are being used, should consider the adverse effects of drug-drug interactions, and should examine the necessity for each additional prescription being contemplated and the desirability of making the patient a more involved and understanding drug consumer.

Finally, the goal of improving quality of life particularly increases the importance of those health care detection and screening efforts designed to uncover

> . . . still minor disabilities which, if left undiagnosed and untreated, can lead to severe handicap. Such conditions which are very much amendable to early detection and treatment include glaucoma, hypertension, some types of anemia, depression, hearing disorders, diabetes, some cancers, and over-medication.[50]

RECOMMENDATIONS

In light of these analayses, we make the following recommendations on acute medical care financing and organization, long-term care, and preventive medicine and health promotion.

Financing and Organization for Acute Medical Care

- A continued examination of health care and social service delivery systems is desirable to produce a better organized and integrated approach to meeting the needs of the elderly more efficiently.
- Traditional health and mental health agencies should be encouraged to collocate their services within a senior center, thereby maximizing the access of that service to older persons and fulfilling the mandate to reach older persons. Also, senior citizens are thereby enabled to share as volunteers in planning, promoting and carrying out such health programs and goals as health check-ups, maintenance of wellness, and helping other senior citizens with Meals on Wheels, fellowship, and friendship.
- The Department of Health and Human Services should investigate methods of modifying provider reimbursement under Medicare in order to alleviate inflationary pressures on the Medicare trust funds. The Department should determine the effects of departing from retrospective cost-based reimbursement and should identify substitute methods that may produce incentives for greater efficiency.
- Public programs should be reformed to give beneficiaries and providers incentives to use lower cost settings where feasible and consistent with preserving the quality of care.

- The elderly should be permitted to use their Medicare benefits to enroll in private health plans meeting certain minimum standards for coverage and financial stability. Through such a voucher system, beneficiaries would be free to buy coverage tailored to their individual needs and to benefit from their willingness to enroll in efficient plans. Beneficiaries wishing to remain in Medicare should be free to do so.
- To facilitate the development of a voluntary voucher program, the Medicare and Medicaid programs should undertake further experimentation with innovative service delivery and financing arrangements such as the ongoing demonstration involving prepayment to HMOs.

Long-Term Care

- States are encouraged to use their existing authority to provide a broader spectrum of long-term care services.
- A full range of setting and services should exist so that individuals have maximum choice in living arrangements and services.
- Limited public resources should, to the extent feasible, be targeted on those functionally disabled individuals who, without aid, would enter expensive nursing homes. Those most at risk include frail elderly individuals who have no immediate family and are also poor.
- The delivery system for long-term care services should be rationalized to ensure continuity of care and encourage efficiency in the delivery of services.

Preventive Medicine and Health Promotion

- Emphasis should be placed on developing and disseminating educational materials for the elderly, as a component of health promotion efforts by Federal, State and local governments, as well as private entities.
- The health policy of the Nation should be to:
  a. Improve the health of all Americans, especially the elderly
  b. Contain health care cost, and
  c. Focus attention on health promotion and disease prevention.
- Additional consideration needs to be given to the benefits the elderly can derive from behavioral and lifestyle modifications within individual control. Information regarding appropriate patterns and probable benefits need to be made a part of health education for the elderly and for those who serve them.
- Restructure the health care delivery system so that preventive medicine and wellness are primary objectives and take immediate action to place temporary limits on the rate of increase in hospital costs.
- Emphasis should be given to a comprehensive review of prevention-oriented screening procedures for the elderly to determine their medical efficacy. In addition, attention should be given to the cost-effectiveness of such procedures. Results of that review need to be widely disseminated to the elderly and to health professionals, to better target prevention efforts and to provide the basis for considering what services are cost-effective from the viewpoint of the individual, the health service delivery system, and third-party payers.

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Final Report the 1981 White House Conference on Aging

Volume 2
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Proceedings

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December 3, 1981

Committee 4
Promotion and Maintenance of Wellness

Chairman: Madge L. Myers
Vice-Chairman: Virginia Boyack, Ph.D.
Staff Director: Holly Caldwell

The Committee Agenda was made up of five issues:

1. The role of nutrition, exercise, stress, and activity in the promotion and maintenance of wellness
2. The role of health, education across the adult life cycle
3. The role of the economics of wellness
4. The role of self-care and mutual help
5. The role of substance misuse — including drugs, alcohol, and tobacco — in the maintenance of wellness.

The resolutions passed by issue are as follows:

ISSUE #1: The role of nutrition, exercise, stress, and activity in the promotion and maintenance of wellness

Be it resolved that:

- Government agencies and private agencies be urged to disseminate information to the elderly stressing: (1) the importance of good nutrition, exercise, and an active lifestyle to their physical well-being; and (2) specific guidelines for doing so.
- To promote and maintain a sense of well-being among seniors, mental, spiritual, and physical health should be included in all concerns.
- We should develop a national health care policy that includes programs at all levels of community structure in order to provide nutritional assessments, exercise programs, and health care management for all citizens.
- Nutrition programs for older Americans shall include provisions for nutrition education, transportation services, and recognition of special populations. This shall be done in partnership between public, private and nonprofit sectors.
- Registered dieticians should be reimbursed by Medicare, Medicaid and private insurance for counseling services on physician-prescribed therapeutic diets.

MINORITY REPORTS:

- One supplemental statement in opposition to the resolution on reimbursement of registered dieticians.

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- One additional view that nutrition programs for the elderly include special services for minority populations.

ISSUE #2: The role of health education across the adult life cycle

Be it resolved that:

- Community mental health centers be required to allocate mental health professional and support staff and funds *proportionate* to the percentage of older adults in the catchment area.
- Since individuals make decisions regarding health and wellness, educational programs must address motivation of individuals.
- Education in geriatrics, gerontology for health professionals — including but not limited to medicine, nursing, physical and occupational therapy, audiology, psychology, pharmacy, podiatry, public health, optometry, and dentistry — should be required by the accrediting bodies for each of these professions.
- The elderly be further educated in the safe and effective use of prescription medicines, and that industry, consumers, health professionals, and government officials provide for the continued transfer of safe and effective prescription-only ingredients to nonprescription (over-the-counter) status.

ISSUE #3: The economics of wellness

Be it resolved that:

- Tax incentives be given to companies who sponsor preretirement and postretirement programs that include the promotion and maintenance of wellness.
- This Committee goes on record endorsing the passage of HR 3827, sponsored by the Honorable Claude Pepper, on June 4, 1981, and other legislation that will require reimbursement of individuals for expenses paid for preventive care and the maintenance of wellness.
- The Congress and the President should develop a national health policy, involving Federal, State, and local governments and the private sector, which will cover all groups and which will guarantee all Americans full and comprehensive health services, irrespective of income, and allow consumer access to information and assure national health planning and control.
- The Federal Government should encourage preventive care to avoid institutionalization by providing reimbursement for such services as (a) relevant immunizations, (b) periodic screening, and (c) basic physical examinations for older persons.
- We affirm support of the HMO Act of 1973 as amended in 1976 and 1978. We recommend that the Federal Government's role be strengthened by amending regulations that restrict Medicare reimbursement on a capitated basis.
- Two additional view statements that any studies of national health policy should consider cost implications of any service expansion.
- One additional view that the Committee was irresponsible in not discussing the fiscal impact of the resolutions it passed.

ISSUE #4: The role of self-care and mutual help

Be it resolved that:

- Self-care and mutual help programs for older people be provided by public and private funds. These programs will provide the consumer with direct access to the health professional of their choice, as needed for the promotion and maintenance of health through self-care and mutual help.
- To remain independent, people with non-insulin-dependent diabetes and cardiorenal and hypertension problems must follow carefully planned, physician-prescribed therapeutic diets and regimens. Counseling should be provided by registered dietitians, paid by Medicare, Medicaid, and private insurers.
- To support mutual help, tax credits should be provided for families who are paying for home care assistance, respite care, transportation, and other services for elderly family members who either reside with their families or independently.
- A coordinated program should be developed to disseminate information to acquaint older Americans in every community with all the available resources for in-home care.
- Self-care, mutual help, and health assessment/health counseling programs be established in, but not limited to, such focal points as senior multipurpose centers, meal sites, adult day care centers, religious senior centers, and housing centers.
- The Secretary of the Department of Health and Human Services should encourage the private sector to support demonstration projects in self-care.
- The financial resources of local, State, and national agencies, and health insurance entities

be so designed that family members be paid a wage for caring for loved ones at home.

- Health assessment centers be established for older Americans as a special effort toward promoting and maintaining wellness. These would serve as health education resource centers and a means of coordinating and ensuring appropriate use of health services.
- The Federal Government should provide financial support for the development of nationwide demonstration projects in geriatric health promotion which include all the elements of the wellness approach: self-responsibility, physical fitness, stress management, and nutritional and environmental awareness.

MINORITY REPORTS

- One additional view opposing any decrease in government regulation at prescription medications.
- One additional view in the form of a report entitled. "Aging and Health: The Role of Self-Medication," submitted for the record.
- One additional view opposing government payment to family members for caring for home-bound relatives.
- One additional view requesting a cost-benefit analysis of assessment centers and calling for no additional Federal funds to be spent on assessment centers.

ISSUE #5: The role of substance misuse — including drugs, alcohol, and tobacco — in the maintenance of wellness.

Be it resolved that:

- We increase the taxes on tobacco and alcohol and use the increased resources to promote public education programs to combat the long-term harm of these substances.
- Elderly people be routinely cautioned about the potential hazards of drug-alcohol interactions.
- The public and private sectors combine efforts to direct a public education and service campaign to disseminate information concerning interaction among drugs and between alcohol and drugs.
- The Federal Government not subsidize toxic substances including, but not limited to, alcohol, tobacco, pesticides, and harmful food additives.

MINORITY REPORTS

- One additional view to delete the word "pesticide" in the resolution on Government subsidy of toxic substances.
- One additional view that no person be denied physician-approved medication because of inability to pay.

This concludes the resolutions, supplemental statements, and additional views on our five agenda items. There were three general minority reports as follows:

- One additional view that the Committee did not appropriately use the experts provided, and that its resolutions would probably have been different and of greater ultimate benefit to the elderly if it had used the experts.
- One supplemental statement that the Committee's report be voted on by the Conference separate from the other 13 Committees' reports.
- One additional view on this same (above) request.

Committee 5

Health Care and Services

Chairman: Dr. William R. Hunt, M.D.
Vice-Chairman: Dr. Jerald Schenken
Staff Director: Larry A. Oday

The Committee on Health Care and Services passed 38 resolutions covering issues in four broad subject areas. We shall describe the resolutions, as well as the supplemental statements and additional views in each of the four agenda areas.

I. REIMBURSEMENT AND FINANCING

A. Four resolutions were passed, after debate, endorsing the following:
1. Tax credits as an incentive for families to maintain elderly relatives in their homes;
2. Prospective payment, under Medicare and Medicaid, to institutions;
3. Prospective payment, under Medicare and Medicaid, to practitioners;
4. Shifting of Medicare and Medicaid to a system that places greater emphasis on competition between third-party payers and health care providers.

B. Three resolutions were passed, without debate, endorsing:
1. Continuation of the search for a National Health Care Security plan;
2. Improvement and maintenance of the health of all Americans;
3. Strong penalties for fraud in the Medicare and Medicaid programs.

C. *Supplemental statements* are as follows:
1. An endorsement of catastrophic health insurance through private insurance plans;
2. An endorsement of a comprehensive national health care plan for all Americans;
3. An endorsement of development of day hospital services for the elderly.

D. One *additional view* was submitted endorsing tighter internal controls on recording Social Security payment checks received.

II. RESEARCH, EDUCATION, AND TRAINING

A. Five resolutions were passed, after debate, endorsing the following:
1. Additional education, research, and training in care for the elderly as critical for all health professionals;
2. Allocating funds for medical research to investigate the aging process;
3. Education and research to develop quality long-term care services and maintenance of health;
4. Federal financial help to induce health practitioners to go into the practice of geriatrics;
5. Educational programs to persuade all citizens to discontinue the use of tobacco.

B. One *additional view* was submitted recognizing the International Year of Disabled Persons.

III. HEALTH CARE SERVICES

A. Six resolutions were passed, after debate, endorsing:
1. Expansion of Medicare to cover outpatient prescription drugs, eye exams, foot care, routine dental care, dental prosthetics and hearing aids, and to change Medicare/Medicaid policy to encourage greater use of non-institutional long-term care;
2. Expansion of mental health services for older adults;
3. Expansion of Medicare/Medicaid to include hospice services;
4. Expansion of Medicare to include nurse practitioners and physician assistants with respect to Medicare reimbursement policies and without onsite physician supervision and to eliminate limits on

physician visits for nursing home patients;
5. Expansion of benefits for long-term care;
6. Expansion of Medicare to include outpatient hospital laboratory services.

B. Five resolutions were passed, without debate, endorsing:
1. Expansion of Medicare and Medicaid for home health care and in-home services;
2. Expansion of Medicare for comprehensive foot care;
3. Removal of the limitations on Medicare reimbursement for mental health services;
4. Establishment of in-home care as a viable alternative to institutional care with appropriate changes in Medicare reimbursement policy to accomplish this;
5. Expansion of Medicare to include adult day care, hospice care and ambulatory care.

C. Two *supplemental statements* were submitted, endorsing:
1. Health care payment mechanisms that recognize nurses as providers of a full range of nursing services;
2. The inclusion of case management services under Medicare.

D. One *additional view* was submitted endorsing dental care coverage under Medicare Part B.

IV. HEALTH CARE DELIVERY SYSTEMS

A. Eleven resolutions were passed, after debate, endorsing:
1. Nationwide preventive programs such as screening and nutritional education programs;
2. Various financial incentives to encourage health care providers to locate in rural areas, small towns and inner-city areas;
3. The appointment of an ombudsman for health care and services in each State;
4. Additional positions for health care providers be provided in the Veterans Administration to take care of the health needs of our Nation's veterans;
5. All senior citizens of this country residing in the U.S. Trust Territories and Puerto Rico be entitled to the same rights and privileges as those residing in a State;
6. That pharmacists review use of medications in intermediate care facilities;
7. State legislation to expand the role of the pharmacist in drug selection, monitoring drug use, and educating patients;
8. Location of health and mental health agencies within senior centers;
9. Programs that provide services for the elderly should include provisions for transportation;
10. HMO's accepting more elderly persons as members;
11. A national health care policy for aged Native Americans.

B. Four resolutions were passed, without debate, endorsing:
1. Research on health service delivery;
2. Greater sensitivity to ethnic and cultural differences in the delivery of health care services to the elderly;
3. The elimination of fraud and abuse, and administration inefficiency in health care programs;
4. That the official theme of this Conference be "Happiness is Being Needed".

C. Four supplemental statements were submitted:
1. Condemning the idea that, after nuclear war, the elderly would have to eat contaminated food;
2. That public and private policy secure to all older Americans access to quality health care consistent with their own needs and preferences and with maximum control over their own lives;
3. Endorsing various recommendations by NRTA/AARP concerning health care and long-term care;
4. Endorsing the provision of access to one single primary source of good primary care for each elderly person.

D. One *additional view* was submitted endorsing mobile health care systems.

V. One *procedural resolution* was adopted stating that it was the desire of the committee that the questionnaire be issued in duplicate so that one copy can go to the Conference and another to the State Coordinator of Aging.

Final Report the 1981 White House Conference on Aging

Volume 3
Recommendations, Post-Conference Survey of Delegates

November 30, 1981-
December 3, 1981

Committee 4

PROMOTION AND MAINTENANCE OF WELLNESS

Summary of Changes made in Committee 4 From Previous Printing

Added Recommendations

The following recommendations were passed by Committee 4 during the 1981 White House Conference on Aging and omitted from the previous printing. They have been added to the recommendation section of the listing for Committee 4.

1. RECOMMENDATION 124A.
2. RECOMMENDATION 124B.
3. RECOMMENDATION 124C.
4. RECOMMENDATION 124D.
5. RECOMMENDATION 124E.
6. RECOMMENDATION 124F.
7. RECOMMENDATION 124G.

RECOMMENDATION NUMBER 107

Government agencies, at both state and national levels, and private agencies be urged to aggressively disseminate information to the elderly stressing (1) the importance of good nutrition, exercise, and an active lifestyle to their physical well-being, and (2) specific guidelines for doing so.

Implementation:

Dissemination of the recommendations and proceedings of this WHCOA to appropriate governmental agencies and officials will bring this to their attention. An attendant letter from the White House urging implementation should give it a good start.

Also part (2) of the motion indicates what is needed.

RECOMMENDATION NUMBER 108:

To promote and maintain a sense of well-being among seniors—mental and spiritual, as well as physical health should be specifically included in all concerns (holistic approach).

Implementation:

Implementation is contained in the proposal itself.

RECOMMENDATION NUMBER 109:

Nutrition programs for older Americans shall include provision for nutrition education, transportation services, and recognition of special populations. This shall be done within a framework of partnership between public, private and non-profit sectors.

Implementation:

To incorporate this language in the implementation plans of all resolutions. Priority funding to be given by Congress to these three issues.

RECOMMENDATION NUMBER 110:

Tax incentives be given to companies who sponsor pre-retirement and post-retirement programs which include the promotion and maintenance of wellness.

RECOMMENDATION NUMBER 111:

We increase the tax on tobacco and alcohol and use the increased revenues to promote public education programs to combat the longer term harm of these substances.

RECOMMENDATION NUMBER 112:

Whereas the present Medicare program does not provide reimbursement for preventive care and maintenance of wellness,

Be it resolved that this committee goes on record endorsing the passage of the Medicare Reform Package of 1981, H.R. 3827, sponsored by the Honorable Claude Pepper, on June 4, 1981, and other legislation which will require reimbursement of individuals for expenses paid for preventive care and the maintenance of wellness.

RECOMMENDATION NUMBER 113:

Be it resolved that this Conference recommends to the Congress and the President to develop a national health policy involving federal, state, and local governments, the private sector which will cover all groups and which will guarantee all Americans full and comprehensive health services irrespective of their income, allow consumer access to information and assure national health planning and control.

Implementation:

To this end we recommend a joint Senate House Subcommittee on Health and Aging to hold and open hearings in every area in the country in preparation for the necessary enabling legislation.

RECOMMENDATION NUMBER 114

The Federal Government should encourage preventive care to avoid institutionalization by providing such services as (a) relevant immunizations, (b) periodic screening, and (c) basic physical examinations for older persons. Reimbursement under Medicare/Medicaid to all qualified health providers and service settings, e.g., home care settings and ambulatory facilities will provide the primary source of en-

couragement to increase such service utilization. Given a service utilization increase, federal health program expenditures will be used in a more cost-effective manner.

RECOMMENDATION NUMBER 115:
We affirm support of the HMO Act of 1973 as amended in 1976 and 1978. We recommend that the Federal Government's role be strengthened by amending regulations that restrict Medicare reimbursement on a capitated basis.

RECOMMENDATION NUMBER 116:
Be it resolved that the Federal Government not subsidize toxic substances including, but not exclusive of, alcohol, tobacco, pesticides, and harmful food additives which are a deterrent to wellness.

RECOMMENDATION NUMBER 117:
The public and private sector combine efforts to direct a public education and service campaign to disseminate information concerning interaction among drugs and between alcohol and drugs to promote and maintain wellness.
Implementation:
It is recommended that funds within the National Institute of Drug Abuse and other sources be used to accomplish these objectives.

RECOMMENDATION NUMBER 118:
Since many elderly who take multiple drugs are not aware of the potential hazards when taken in combination with alcohol,

Be it resolved that elderly people should routinely be cautioned of the potential hazards.
Implementation:
Medical Schools should carry out a plan for education on these hazards.

Prescription and over-the-counter drugs that do have potential hazards must carry warning on label.

Physicians, when prescribing drugs, must caution patient.

Pharmacists, when dispensing drugs, must caution patient.

RECOMMENDATION NUMBER 119:
Be it resolved that to remain independent, people with non-insulin-dependent diabetes, cardio- renal and hypertension problems must follow carefully planned physician prescription therapeutic diets and regimens. Counseling should be provided by Registered Dieticians, paid by third party payments by Medicare/Medicaid and private insurers.
Implementation:
This is an attempt to transfer a relatively small portion of Medicare A funds to Medicare B (outpatient) payments. Since the cost of therapeutic out-patient diet counseling is dramatically less than that of hospitalization or institutionalization, the odds are strongly in favor of its paying off.

RECOMMENDATION NUMBER 120:
Since promotion of wellness is a lifelong process, let us develop a national health care policy that includes programs at all levels of community structure in order to provide nutritional assessments, exercise programs and health care management for all citizens.
Implementation:
The Secretary of the Department of Human Services shall appoint a task force to develop a national health care policy as defined in the resolution. The task force shall complete its charge within 12 months, and it shall take into consideration existing public and private sector programs and initiatives such as the National Objectives for Disease Prevention and Health Promotion. In formulating this policy the Task Force shall incorporate the resources of the media, business and industry, and other private organizations, local, state, and federal agencies with consideration of ethnic, cultural and other community differences.

The Secretary of Human Services shall make this proposed national health policy available to all health professional, national and statewide citizen organizations for study and comment.

The Secretary shall then have legislation prepared with legislative support that can then be submitted to Congress for adoption and implementation.

In order for this policy to be carried out, participants at this Conference are urged to maintain vigilant interest in the long term implementation of this long needed policy.

RECOMMENDATION NUMBER 120A:
Be it resolved that Community Mental Health Centers be required to allocate mental health professional and support staff and funds *proportionate* to the percentages of older adults in the catchment area.
Implementation:
1. That NIHM establish regulations effective within one year that Community Mental Health Centers implement said resolution;
2. If block grants are used to channel funds to State Department of Mental Health, then the Federal Government should require the states to implement said resolution.

RECOMMENDATION NUMBER 121:
Be it resolved that the Secretary of the Department of Health and Human Services will encourage the private sector to support demonstration projects in self care.

The sponsors of these projects could include, but not be limited to the following types of groups:

- Health care providers including physicians, nurses and all other qualified licensed registered health care providers, hospitals, pharmaceutical companies, nursing homes, health maintenance organizations
- Private employers
- Universities
- Insurance companies

Supporting Analysis
Budget impact—minimal.
No legislation or regulation required to implement. Secretary's office implements along with the private sector.

There is evidence to suggest that the private sector, working at the local level, can design and implement programs of this kind and can achieve good results with an efficient program without government regulation and legislation.

Private sector groups could expect to get good publicity and to generate community good will if they undertook these programs.

Implementation:
The Office of the Secretary can develop these programs in cooperation with the private sector.

RECOMMENDATION NUMBER 122:
Health assessment centers be established for older Americans as a special effort toward promoting and maintaining wellness. This would serve as a referral point for multidisciplinary health assessment, a health education resource center and a means of coordinating and ensuring appropriate use of health services.

Implementation:
1. Rely on existing health facilities, services and professionals.
2. Provide for comprehensive health assessment reimburseable through Medicare.

RECOMMENDATION NUMBER 123:
Be it resolved that self-care, mutual help and health assessment/counseling programs be established in—but not limited to—such focal points as senior multipurpose centers, meal sites, adult daycares, religious senior centers, housing centers.

Rationale 1) They already exist as nucleus places in operation, 2) logical for access and outreach, 3) students and volunteers are or should be in and out of these places, 4) care be conducted as clinics and could consider sliding scale flexipay.

Implementation:
1. Call on health professionals and volunteers from service agencies and educational programs to assist in conducting such programs with incentives.
2. Employ the widest possible range of health professionals and those lay people with specialized training in aging.
3. Set up a National Senior Health Corps created by governmental and private resources to serve in the above mentioned program and also to promote older persons as resources. These persons should receive training as needed. Persons would serve as full or part-time workers or volunteers as desired by the program and/or by the individuals. See "Report of the Technical Committee on Health Maintenance and Health Promotion (1981) pages 57 and 58.

RECOMMENDATION NUMBER 124:
The financial resources of local, state, government and insurances be so designed that family members be paid a wage for caring for elderly loved ones, if they desire to keep them at home.

Implementation:
The funding source should be the same as those presently used for outsiders. The only change is the funding of a family member instead of an outside caretaker.

RECOMMENDATION NUMBER 124A:
Be it resolved that self-care and mutual help programs for older people be provided by public and private funds. These programs will provide the consumer with direct access to the health professional of choice, as needed for the promotion and maintenance of health through self-care and mutual help. The purpose of these programs is to provide a setting where health education, health maintenance and disease prevention activities can occur.

Implementation:
Provide training for non-professional health workers, the older adult, the family, and others on matters needed to support self-care and mutual help.

RECOMMENDATION NUMBER 124B:
Be it resolved that to support mutual help that tax credits should be provided for families who are paying for home care assistance, respite care, transportation and other services for elderly members, similar to the present child care credits. These credits should be applicable whether the elderly reside with their families or independently.

Implementation:
Further study and demonstration recommended by fiscal 1982/83 with special emphasis on disincentives for abuse.

RECOMMENDATION NUMBER 124C:
Be it resolved that a coordinated program of "in-

home" care for the elderly be developed utilizing existing programs and supplemented by such new programs as may be necessary to maintain older Americans in their own homes with a dissemination of information program designed to acquaint older Americans in every community with the available resources for in home care.

RECOMMENDATION NUMBER 124D:
Be it resolved that since individuals make decisions regarding health and wellness, educational programs must address motivation of individuals.
Implementation:
Ask educational programs to demonstrate effectiveness of programs by outcomes.

RECOMMENDATION NUMBER 124E:
Be it resolved that continuous, high quality information and health education be made available to all citizens, across the life cycle, through every responsible and available channel of communication. Education in geriatrics/gerontology for health professionals, including, but not limited to: medicine, nursing, physical and occupational therapy, osteopathy, dietetics, medical social work, audiology, psychology, pharmacy, podiatry, public health, optometry, and dentistry should be required by the accrediting bodies for each of these professions.
Implementation:
That all channels and forms of communication in the private and public sector should be utilized such as: educational systems and institutions, the mass media of radio, TV, newspapers, magazines, journals and press; churches, governmental agencies, community organizations, civic and fraternal organizations, seminars, model programs, retreats. Frequent individual health status assessments should be the norm.

RECOMMENDATION NUMBER 124F:

Be it resolved that

1. *The elderly be further educated in the safe and effective use of non-prescription medicines; and*
2. *Industry, consumers, health professionals and government officials provide for the continued transfer of safe and effective prescription-only ingredients to non-prescription (over-the-counter) status.*

Implementation:
Recommendation #1 may be implemented under existing laws and regulations; and requires no additional funding or augmentation of personnel; and utilizing existing and future health education programs.

Recommendation #2 may be implemented under the present Food, Drug and Cosmetic Act as amended, with no additional funding or personnel and under current regulations of the Food and Drug Administration with no additional expenditure of resources.

RECOMMENDATION NUMBER 124G:
The Federal Government should provide financial support for the development of nationwide demonstration projects in geriatric health promotion which include all the elements of the wellness approach: self-responsibility, physical fitness, stress management, and nutrition and environmental awareness.

Supplemental Statements

1. At least 20% of the committee members voted to oppose the recommendation, adopted by the majority, that to remain independent people with non-insulin dependent diabetes, cardiorenal and hypertension problems must follow carefully planned, physician prescribed therapeutic diets and regimens. Counseling should be provided by Registered Dieticians paid by third party payments by Medicare/Medicaid and private insurers.
2. The committee chairman include in her summary report to the plenary session on Thursday, December 3, 1981, a request that the WHCoA adopt or reject the report of the committee on promotion and maintenance of wellness by a separate vote.
3. Be it resolved that the White House Conference on Aging opposes any decrease in regulation of prescription medications which would create an increased likelihood of older persons becoming victims of drug advertising in self-prescription and administration of medications. It is feared that such deregulation would enhance the very real possibility of drug interactions which occur when persons take multiple medication.

Additional Views

1. Be it resolved that this minority report protests restraining the committee from using the experts provided to the Committee. Because we were not allowed to use the experts, except by unanimous consent, it is our feeling that the Committee received inadequate, misleading and inaccurate information. Therefore, we believe the Committee passed resolutions which would have been significantly different in concept, intent and ultimate benefit to the aged if we had been able to fully use the experts.
2. The search for a national health care security plan will continue with due regard to truly unmet needs and a clear regard for the costs of such an effort.

3. At least ten percent of the members of committee #4 disagreed with the recommendation, passed by a majority of the committee, which stated that: "The financial resources of local, state, government, insurances and be so designed that family members be paid a wage for caring for elderly loved ones, if they desire to keep them at home."

4. We do not believe that there is sufficient evidence to support the cost-effectiveness of, or real need for assessment centers. Given this uncertainty and the potential tremendous costs, we ask the following:

   A. That a thorough benefit-cost analysis be attempted before the project be considered.

   B. That in any event, no additional Federal funds be used for this project.

5. Be it resolved: that the Committee on Promotion and Maintenance of Wellness recognize the importance of public and private programs that benefit older Americans; however, it has been irresponsible of this Committee to prohibit the discussion of the fiscal impact of all proposed measures in light of America's current economic and budgetary conditions.

6. That a national health care policy for all older Americans take into account the potential cost implications of any expanded level of service.

7. Because the Chair has refused to report on our committee-as-a-whole caucus that requested a majority vote stating that we wished to be on record as desiring a separate vote on Committee 4 proceedings in the Plenary Session 12/3 we hereby sign a minority opinion. This opinion was voted for inclusion in our summary by a majority of the committee members, but the Chair refused to recognize this vote.

8. No person should be denied necessary medication, approved by a physician, because of inability to pay.

9. Nutrition programs for all elderly persons should include services for the special population (American Indians, Asians, Blacks, Hispanics and other ethnic minorities). These programs should focus on ways to plan and reflect the ethnics' food preference of these groups.

   In implementation of this resolution, special consideration must be given to the unique social and cultural needs of minority populations. Contractors or other providers who are themselves from these populations will be most effective in making social services available.

Implementation Plan
To incorporate this language in the implementation plans of all resolutions.

10. At least 10% of the committee requested the deletion of the word pesticide in the resolution passed under the section of the order of business on The Role of Substance Misuse.

11. At least 10% of the committee members on the Promotion and Maintenance of Wellness wish to enter this informational document (The Proprietary Association: Aging and Health: The Role of Self-Medication. Washington, D.C., 1981.) into the record of these proceedings.

Committee 5

HEALTH CARE AND SERVICES

Summary of Changes in Committee 5 From Previous Printing Added Implementation Statement

1. An Implementation Statement was added to Recommendation 149. This statement was part of the Recommendation as passed by Committee 5 during the 1981 White House Conference on Aging and was omitted from the previous printing.

RECOMMENDATION NUMBER 125:
Traditional health and mental health agencies be encouraged to collate their services within a senior center, thereby maximizing the access of that service to older persons and fulfilling the agency's mandate to reach older persons. Also, senior citizens are thereby enabled to share as volunteers in planning, promoting and carrying-out such health programs and goals as: health checkups, maintenance of wellness, and helping other senior citizens with Meals on Wheels, fellowship and friendship.
Implementation:
Agreements between senior citizens centers and health and mental health agencies. Recruitment, training and supervision of volunteers by senior citizens centers.

RECOMMENDATION NUMBER 126:
State legislation mandate that pharmacists serve and assist the elderly in the community by:
1. Assisting medical practitioners in selecting drug therapy that is rational and appropriate to the elderly patient,
2. Maintaining medication profiles and drug histories for elderly clients to help monitor drug use and avoid duplication of therapy, drug misuse and drug interactions,
3. Monitoring drug therapy for effective response and help identify drug related side effects and toxicity,
4. Teaching the elderly patient about the purpose of use and proper use of prescription and non-prescription medication administration, and
5. Training patients in the proper use of appliances and devices and the proper storage of medications.

Implementation:
State legislation in cooperation with State Boards of Pharmacy. Federal legislation. Drafting of details could be accomplished with the help of APHA (American Pharmaceutical Hospital Association), American Society of Hospital Pharmacists, American Association of Colleges of Pharmacy (AACP).

RECOMMENDATION NUMBER 127:
Because of the health needs of the increasing number of our nation's veterans (presently 3 million to become over 7 million within 10 years) that additional positions for health care providers, especially physicians, nurses and social workers be provided.
Implementation:
Additional funds be granted to the Veterans Administration for these critically needed positions.

RECOMMENDATION NUMBER 128:
An ombudsman for health care and services be appointed in each State to ensure that older Americans receive the health services they need and ensure that recommendations adopted at this conference be enforced.
Implementation:
That the Older Americans Act be amended to include an ombudsman for health care and services in each State. This ombudsman will be paid from private and not government funds.

RECOMMENDATION NUMBER 129:
As it pertains to mental health, the official theme of this 1981 White House Conference on Aging be: Happiness is Being Needed.
Implementation:
1. This Health Care and Services Committee should recommend to the leaders of this conference that the above be officially designated as the conference theme for 1981, because one of the major fears of the elderly citizen stems from his conception that he is no longer a useful and needed member of his family or of society.
2. This conference should recommend the promotion of a public relations program encouraging families, churches, and communities to involve the elderly in useful, constructive ways showing them that they are respected, useful and needed.

RECOMMENDATION NUMBER 130:
The Congress allow hospice services to the terminally ill patients to be reimbursed by Medicare and

Medicaid and other third party payers. Services are to be provided by hospice teams accredited by the National Hospice Organization or other approved accrediting agencies.

Implementation:

Modify Medicare and Medicaid laws.

RECOMMENDATION NUMBER 131:

Expanded home health care and in-home services should be available based upon individual needs, with more flexible eligibility requirements for all federal and state funds and private health plans with

Reimbursement at local rates

Simplified administrative regulations to allow for more direct services

Tax incentives to encourage family and local participation.

Implementation:

A full range of home health and in-home services should be developed and available to rural and urban elderly in every community.

Titles XVIII and XIX of the Social Security Act should be modified to allow reimbursement for a variety of in-home services.

Funding should be increased through a reimbursement system that encourages cost-effectiveness.

Congress and State legislatures should provide tax incentives for families who provide care for dependent elderly by actual agreement of parties.

On the federal level, regulations for in-home services and nursing homes should be simplified.

RECOMMENDATION NUMBER 132:

The limitation on Medicare reimbursement for outpatient and inpatient mental health services for the elderly be set at the same level as for other medical services. Furthermore, that cultural and ethnic communities be given special recognition in the delivery of mental health services.

Implementation:

Increase immediately the ceiling for outpatient psychiatric benefits from $250 per year to a more reasonable level; e.g., $1,000 per year, and from 50% to 80% Medicare coverage for these services. Establish a series of demonstration projects to determine feasibility of covering mental health services on the same basis as other services.

RECOMMENDATION NUMBER 133:

Medicare should be broadened to cover adult day care, hospice care and ambulatory care to provide a more balanced and responsive approach to the aged health care.

Implementation:

Amend Title XVIII to the Social Security Act to include adult day care, hospice care and ambulatory care to prevent unnecessary institutionalization.

RECOMMENDATION NUMBER 134:

Medicare and Medicaid programs shift to a system that places greater emphasis on private market forces and fosters greater competition between third-party payers and between providers of health care.

Implementation:

Federal legislation for Medicare and Medicaid, as well as State legislation for Medicaid.

RECOMMENDATION NUMBER 135:

The Medicare program shift from reasonable charges to negotiated prospective payment, on a regional basis, as the basis for payment to practitioners.

Implementation:

Federal legislation and HCFA reform of existing regulations to conform to the new legislation.

RECOMMENDATION NUMBER 136:

The Medicare and Medicaid programs should shift from reasonable cost reimbursement to negotiated prospective payment as the basis for payment to institutions.

Implementation:

Federal legislation would be necessary to give HCFA the authority to restructure the system. State legislation would also be needed for Medicaid.

RECOMMENDATION NUMBER 137:

Families should be encouraged to maintain elderly relations in their homes as an alternative to institutionalization through meaningful tax credits and appropriate modifications in the Social Security Act.

Implementation:

Congress should remove anti-family provisions in the Supplemental Security Income law. For example: (1) the one-third reduction in the basic grant for SSI recipients residing in the household of another if they receive food and shelter, and (2) the sixty dollar maximum cash contribution that a family can make in a quarter to the aged SSI relative before the contribution will count as income. The sixty dollar figure should be increased to a reasonable amount.

RECOMMENDATION NUMBER 138:

The health policy of the Nation should be to:

a. Improve the health of all Americans, especially the elderly,

b. Contain health care costs, and

c. Focus attention on maintaining health and avoiding illness.

Implementation:

Restructure the health care delivery system so that preventive medicine and wellness are primary objectives and take immediate action to place temporary limits on the rate of increase in hospital cost. State

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mandatory rate review programs should be a primary focus in this regard.

RECOMMENDATION NUMBER 139:
The Congress enact strong, Federally mandated penalties as well as enforcement against fraud in Medicare/Medicaid programs.

That the medical professions be protected against fraudulent recipients by use of imprinted photo IDs on forms. That recipients must sign off itemized billings as received and other loopholes of fraud and abuse.

Implementation:
Be referred to Congressional Committees for legislation.

RECOMMENDATION NUMBER 140:
The search for a National Health Care Security plan continue.

Implementation:
An ongoing advocacy for support of a National Health Plan.

RECOMMENDATION NUMBER 141:
In view of the increasing numbers of elderly requiring health care, that additional education and research training is critical for physicians, nurses, nurse-aides, home health aides, social workers, physical therapists, occupational therapists, registered dieticians, pharmacists, podiatrists, osteopathic physicians, dentists and other health professionals in care of the elderly.

Implementation:
We recommend that 0.1% of the Federal health service dollar be appropriated to research, training and education of health professionals in care of the elderly by Federal agencies, particularly National Institute on Aging, Division of Nursing, HRA and National Institute of Dental Research.

If so resolved, a written message indicating this confrence support should be sent to administrators to all health professional schools in the United States by the Chair of the White House Conference on Aging.

RECOMMENDATION NUMBER 142:
The Congress allocate a portion of the money designated for medical research to be directed to projects designed to investigate the aging process.

Implementation:
Through programs of the National Institute of Health and through medical schools and private industry.

RECOMMENDATION NUMBER 143:
Education and research to develop quality long-term care services which people can afford be provided; that people be educated to maintain their own good health; that education and training be provided for all staff of agencies providing care; and that research on the aging process and well-being of the aging population be continuing.

RECOMMENDATION NUMBER 144:
That physicians, nurses, nursing home administrators, and other health practitioners be encouraged to go into the practice of geriatrics/gerontology through financial help available from the Public Health Service of the U.S. Government.

Implementation:
That Public Health Service grants be expanded to include nurses and other health practitioners.

That public relations activities be conducted to publicize the availability of these grant awards.

RECOMMENDATION NUMBER 145:
Congress and the Administration expand and develop adequate and appropriate mental health services for older adults, particularly community mental health services and those in nursing homes and adult foster care placement.

Implementation:
Congress should designate funds specifically for this purpose so that the current 30% of older people needing service, get it, rather than the 4% currently receiving service.

RECOMMENDATION NUMBER 146:
The conference recommend the expeditious implementation of a comprehensive educational program to persuade the aging population, as well as all other citizens of our country, to discontinue the use of tobacco.

Implementation:

A. The White House Conference on Aging should join forces with the American Cancer Society and the American Heart Association, to implement a crash program to get people to stop smoking.
B. We should petition Congress to immediately discontinue the subsidizing of the tobacco industry.
C. The White House Conference on Aging should go on record in the news media and elsewhere to enthusiastically endorse and promote this resolution.
D. This conference should recommend to President Reagan that he personally endorse this resolution and use the powers of his office to persuade our citizens to discontinue this life-threatening habit.

RECOMMENDATION NUMBER 147:
Title XVIII (Medicare) of the Social Security Act should be amended to:

- repeal the requirements for on-site physician

supervision of nurse practitioners and physician assistants;

- reimburse for nurse practitioner and physician assistant services in nursing homes;
- eliminate limits on physician visits for nursing home patients.

Implementation:
Congress should enact such proposed amendments. HCFA should develop regulations to implement such reimbursements.

RECOMMENDATION NUMBER '48:
Comprehensive foot care be provided for the elderly in a manner equal to care provided for other parts of the human body, to permit patients to remain ambulatory.
Implementation:
Remove current Medicare exclusions which preclude comprehensive foot care.

RECOMMENDATION NUMBER 149:
Medicare reimbursement should be expanded to cover primary care, preventive and health maintenance services. These should include out-patient prescription drugs, eye examinations, foot care, routine dental care and dental prosthetics and hearing aids. In order to fund expanded benefits, streamline programs through such mechanisms as Title XXI legislation and State coordination of Titles XVIII, XIX, and XX and the Older Americans Act programs. Also strengthen federal and state efforts to control fraud and abuse by providers of health care services.

Change reimbursement policies of Medicare and Medicaid to encourage the use of non-institutional long-term care whenever medically appropriate. This should include home health, day care, congregate housing, and other community-based arrangements.
Implementation:
Federal and state legislation.

RECOMMENDATION NUMBER 150:
Outpatient hospital laboratory services be reimbursed to hospitals by Medicare Part A at the same level as these services are allowable by Medicare Part B.
Implementation:
Change be by regulation changes either by Congressional action or Departmental action.

RECOMMENDATION NUMBER 151:
National health insurance policy, whether organized through public or private insurance plans, shall provide adequate, universal coverage for a full array of long-term care services for chronically disabled citizens.

Implementation:

- Assure universal insurance coverage of long-term care.
- Finance through a combination of private premiums and public subsidies based on ability to pay.
- Include as an essential part of either Medicare, national health insurance or private health plans.

RECOMMENDATION NUMBER 152:
In-home care be developed as a viable alternative to institutional care; that the reimbursement mechanisms provide for support to home health aides, nurses, therapists, and others who can provide both professional and paraprofessional care in the home setting; and that the voluntary, proprietary and public service systems be encouraged to respond to the need for in-home care in a quality and cost-effective manner.
Implementation:
Both Federal and applicable State legislation should promote the provision of in-home care as an alternative to institutional care (This legislation includes the Social Security titles which address differing types of support).

RECOMMENDATION NUMBER 153:
We consider the needs of the elderly who are well and not in need of various forms of extended care. That we recommend nation-wide preventive physical and mental health assessment programs, including screening and nutritional education programs.
Implementation:
These programs would not place responsibility on Federal financing. Such programs could be centered in already established multi-purpose centers where the greatest number of the elderly are served; or where there are no centers with agencies serving the elderly. Local community facilities could be encouraged to participate; volunteerism also comes into play.

RECOMMENDATION NUMBER 154:
This committee proposes that all senior U.S. American citizens of this country, no matter where they reside (U.S. Virgin Islands, Guam, American Samoa and the Commonwealth of Puerto Rico) be entitled to all the rights and privileges of the citizenship of those residing in the State of the Union, provided that said territories adopt all Federal tax laws.

RECOMMENDATION NUMBER 155:
Programs which provide services for the elderly should include provisions for the transportation component.
Implementation:
Use existing services available—private, public and/or voluntary.

RECOMMENDATION NUMBER 156:
Tax, financial incentives, including educational scholarships should be provided encouraging health care professionals and paraprofessionals to locate in rural areas, small communities and inner-city areas to insure adequate distribution of basic health care and services for the elderly throughout the country.
Implementation:
A plan to include incentives such as cancellation of educational loans, tax deductions and reductions, and educational scholarships for health care and services personnel (physicians, nurses, social workers, psychologists and paraprofessionals) be instituted. The plan should require service in high risk areas (rural, inner-city, Indian reservations, etc.).

RECOMMENDATION NUMBER 157:
Pharmacists be responsible for reviewing the appropriate use of medications in Intermediate Care Facilities as is already mandated for Skilled Nursing Facilities by Federal and State laws.
Implementation:
Federal legislation
State legislation
Drafting of legislation and detail could be done in cooperation with local and national pharmaceutical associations.

RECOMMENDATION NUMBER 158:
Health Maintenance Organizations (HMOs) be encouraged to accept more members over 65 because at present they prefer the young and employed as better financial risks.

RECOMMENDATION NUMBER 159:
In facing escalating health service costs for the elderly, we must adequately support research on health service delivery.

RECOMMENDATION NUMBER 160:
A national health care policy be established for aged native Americans through the process of a needs assessment, a service delivery plan, and a periodic evaluation to measure service delivery and quality of care.
Implementation:
- That a national needs assessment in health care for Indian elderly be conducted immediately, and
- That a national panel of Indian elderly be established to review the assessment and make recommendations for the development of national policy, and
- That the delivery of health care services be evaluated annually to maintain compliance with the new National Health Care Policy for Native Americans.

RECOMMENDATION NUMBER 161:
Physical and mental health care services to the elderly are made available in a way that reflects sensitivity and awareness of their ethnic and cultural differences. Very often lack of sensitivity of language and cultural barriers prevent the elderly from utilizing much needed physical and mental health services.
Implementation:
Information regarding ethnic and cultural differences should be included in the training curricula of the various professional schools. Service providers should also be encouraged to utilize professionals and paraprofessionals of the same ethnic background, whenever possible, to provide the elderly with physical and mental health care services.

RECOMMENDATION NUMBER 162:
This committee and the White House Conference on Aging be placed on record as advocating with equal emphasis the elimination of administrative inefficiency, abuses, and frauds as well as the elimination of frauds and abuses by recipients of the various health and human services provided by the Federal Government.
Implementation:
Educate administrators of such programs in the sound business and administrative practices known to and applied in the private sector, and enforce their application of Federally-supplied services.

Supplemental Statements

1. We condemn the suggestion of the Study by the Oakridge National Labs that, after nuclear war, elderly be put in jobs and asked to eat food with radiation risks on grounds that it would protect younger people from risk of cancer which will result from long-term exposure to radiation.
   Implementation:
   Federal Government should act to prevent such a situation by working within the framework of age discrimination laws now in operation, and having additional laws enacted to protect all Americans in a nuclear disaster.

2. I move to amend the motion on in-home care for older adults with their families as follows: To include case management services to assure quality of care and eliminate abuse, to include training for the family and eligibility for nursing and other support services. Services should be paid for on a sliding fee scale. For very low income persons reimbursement may be provided if needed to assure adequate funding for heating and nutrition and other needed services.
   Implementation:
   Amend the Society Security Act.

3. The Health Care Financing Administration establish a reimbursement program that allows the development of Day Hospital services for the elderly which provides needed acute care and rehabilitative services, while eliminating the need for overnight stays where medically appropriate.

The Day Hospital service utilizes existing community hospital facilities, reduces the cost of care significantly for numerous illnesses and allows for the family to become a part of the health care team and is an important part of a continuum of care. This measure provides for significant cost containment while maintaining quality care.

4. Whereas the nation, with the passage of the first Medicare legislation in 1965, accepted responsibility for providing health care to the elderly with minimal cost to those served; and

Whereas it is the goal of most older Americans to improve the quality of their lives and maintain maximum functional independence; and

Whereas physical, mental and social health are equally important segments in the total well-being of older Americans; and

Whereas fifteen percent of all older American living in the community and from 50% to 70% of the elderly living in institutions suffer from serious mental or emotional problems; and

Whereas from 10% to 20% of the elderly living in nursing homes could be maintained in the community; and

Whereas expensive and inappropriate care is often provided the elderly only because this care is "covered" by Medicare; and

Whereas many needed health care services are currently excluded from Medicare coverage; and

Whereas the present system of health care for the elderly displays a bias toward institutionalization and discourages preventive health services and maintaining the elderly in the community; now therefore be it resolved,

That a new integrated national policy for health and long-term care reflecting the specific and unique needs of all elderly Americans be developed; and be it further resolved,

That health policy be based on improving the health of older people, avoiding illness as recommended by the National Retired Teachers Association and the American Association of Retired Persons; and be it further resolved,

That long-term care policy provide for a continuum of services with options based on a network of community-based long-term care centers functioning as providers, payers, certifiers and evaluators of services as recommended by the National Retired Teachers Association and the American Association of Retired Persons.

Implementation:

That legislation implementing the new national policy draw on the experience of model and demonstration programs in the nation including California's Multipurpose Senior Servires Project (MSSP), Senior Care Action Network (SCAN) of Long Beach, California, San Francisco's On Lok, the UCLA/UCS Long Term Care Gerontology Center of Los Angeles and Triage Inc. of Connecticut.

5. That Legislation be provided by Congress and the President to amend the Society Security and Older American Acts in the field of primary health care; to provide that each elderly person have access to at least one single primary source of good primary care, such care should emphasize responsible and continuing surveillance by a primary care practitioner usually a family physician, general internist, or gerontological nurse and/or nurse practitioner or physicians assistant Periodic preventive services, referral to specialized services, long-term care, at home or institutionalized and including centralized comprehensive medical records are essential components of primary care. A cost containment plan should be provided.

Implementation:

It is recommended that the above legislation be passed by both Houses of Congress and signed by the President of the United States.

6. There be health care payment mechanisms which recognize nurses as providers of a full range of nursing services. These nursing services should be available in settings such as hospitals, nursing homes, home health agencies, private homes, interdisciplinary service agencies, private or group practices.

The older adult has the right to choose the provider and the setting in which he/she will receive health care services. Along with family members, older adults must be given decision making power to plan for and select the care they need to enable them to function as independently as possible.

Older adults seeking health care in any setting have the right to a full range of nursing services.

Certified nurses or master prepared nurses would be covered.

Implementation:

Both the public and private insurance industries

should be restructurd to provide payment for nurse-authorized nursing services in any setting chosen by the older adult.

Develop legislative language seeking funding for costing out nursing services.

Develop regulatory language related to payment mechanisms for nursing services.

7. Congress enact a comprehensive national health care plan for all Americans.

8. The Congress of the United states encourage the provision of private catastrophic health insurance for all ages through private insurance companies. There would be public financing of premiums for the poor, based on a means test.

9. Older Americans are, first and foremost, individuals who together reflect a wide diversity of interests, talents, values, and aspirations. In our judgment, this common achievement entitles our older citizens to a full recognition of their individual human dignity, to respect for their achievement of long life, and to the opportunity to exercise their rights and responsibilities as fully valued citizens. Public and private policy must secure to all older Americans:

   - access to quality health care consistent with their individual needs and preferences; and
   - maximum possible control over the conduct of their own lives and the pursuit of their own goals.

Additional Views

1. Rural health care services be made accessible for the elderly by developing a mobile health system which includes transportation and health teams to provide health care.

Implementation:
Implementation through Medicare/Medicaid.

2. Dental care for the senior population be provided under Part B of Medicare.

Implementation:
Amend Public Laws covering Medicare—Title XVIII—to accomplish the above.

*Note—39 State Conferences on Aging had this as a recommendation. The Technical Committee covering Health Care Services also recommended this.

3. The 1981 WHCoA recommends that the Federal Interagency Council of the American Committee of the International year of Disabled Persons address and give emphasis to the issue of aging disabled persons in its observation of the 1981 International Year of Disabled Persons.

Implementation:
To enhance the WHCoA during 1981 International Year of Disabled Persons.

4. FLAGRANT PRACTICES in 1,500 Social Security offices and six regional program centers, as reported by government auditors early 1981 be stopped according the "Integrity Program."

   There were numerous deficiencies in control of cash paid by senior citizens. Soc. Sec. personnel neglected to be aware of fraud. Internal controls were not conducive to a sound system of checks and balances.

   This involves millions of dollars in checks, cash and money orders from older Americans participating in social security programs and sorely needed in social security programs.

Implementation:
Tightening of controls and better checks and balances.

5. The amount of the Social Security checks that have never been cashed, but which the agency has to write off its books as money paid out, thus depriving it of the use of these undistributed funds, be restored to it by the Treasury Department. Now there are some $203 million dollars of these and in the next four years auditors estimate that another $112 million will accumulate. Total $315 million.

Implementation:
Make a change in the book keeping method that would restore these funds to the Social Security Trust Fund at regular time intervals. Social Security checks should carry a date of expiration to alert members to cash their checks promptly.

6. All employed individuals should be covered by the Social Security system. This means that employees of all private firms and State, local and Federal civil servants should be subject to the payroll tax which finances social security cash benefits and the Medicare program. This will enable the Trust funds to be better financed and will make the imposition of the tax more equitable.

Implementation:
Legislative and Executive action.

the 1981
White House
Conference
on
Aging

Executive Summary of Technical Committee on HEALTH MAINTENANCE & HEALTH PROMOTION

NOTE: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging, or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

I. INTRODUCTION

The report of the Health Maintenance and Health Promotion Technical Committee of the 1981 White House Conference on Aging is the distillation of approximately 500 pages of research papers prepared and submitted by the Committee members and consultants in the period between August 8, 1980 and February 1, 1981. The Committee hopes that its report and this executive summary will guide the deliberations of delegates to the 1981 White House Conference on Aging.

Throughout its existence the Committee has regarded prevention of illness as the most cost effective way to promote the health and happiness of older Americans. Nevertheless, only about 2.5 percent of the Federal health budget is allocated to prevention. A "youth bias" in prevention is reflected in our media, in the lack of literature on prevention for the elderly, in the lack of programs with a preventive health focus for older Americans. It is also mirrored in Medicare's failure to reimburse for most preventive health services, though such services could result in reduced need for treatment and institutionally-based medical care at a later time.

Why the lack of interest in health maintenance and health promotion efforts for the elderly? The elderly are perceived as in a period of loss and decline—without a future—so prevention and health promotion appear irrelevant. Since the primary focus of disease prevention and preventive medicine is reduction of risks to health—particularly reduction of premature aging and death—it is easy to see why so many of the elderly who have lived past their average life expectancy have been ignored. A preoccupation with the prevention of premature aging has led health promotion professionals to dissociate from those who are already old. Finally, negative self-images in the elderly themselves prevent their involvement in health maintenance and health promotion.

II. CONCEPTUAL BASE OF THE COMMITTEE

The Health Maintenance and Health Promotion Technical Committee adopted the following definitions to guide the preparation of this report and its recommendations.

- Health is the ability to live and function effectively in society and to exercise maximum self-reliance and autonomy; it is not necessarily total freedom from disease.

- Health Promotion starts with people who are basically healthy and seeks to develop community and individual measures to help them develop lifestyles that maintain and enhance the state of well-being.

- Health Maintenance involves measures to provide social and health care supports that allow individuals to achieve maximum functioning within their own home environments or other appropriate settings. It focuses on overall well-being as well as on disease prevention and early detection of disease.

The Committee believes that the health of the Nation's older citizens can be improved significantly through individual actions as well through actions by public and private decisionmakers to promote safer and healthier environments. The following principles guided the Committee:

- Health maintenance and health promotion for the elderly should concentrate on maintaining or reestablishing a maximum level of function.

- Institutionalization of the elderly should be avoided whenever possible.

- There is commitment to lowering health care costs in the aggregate, while providing appropriate health and social supports to the elderly.

- Health maintenance and health promotion should concentrate on reallocating existing health expenditures and coordinating services, rather than on adding new programs.

- The elderly are an underutilized national resource who have much to contribute to society.

- The elderly should be involved in the planning and implementation of health maintenance and health promotion programs.

III. ORGANIZATION OF THE TECHNICAL COMMITTEE REPORT

The final report of the Health Maintenance and Health Promotion Technical Committee groups the content areas for study into three categories: (1) health maintenance and health promotion services; (2) behavioral issues in health maintenance and health promotion; and (3) special issues in health maintenance and health promotion. Topics in each of these three sections are listed below.

1. Health Maintenance and Health Promotion Services

   The Physical and Social Environments
   Indicators of Change in Physical and Mental Health in Late Life

Rehabilitation
Mental Health
Dental Health
Needed Legislation for Linking a System of Services for the Elderly
Reimbursement for Preventive and Health Maintenance and Promotion Costs for the Elderly

2. Behavioral Issues in Health Maintenance and Health Promotion

The Role of Nutrition in Health Maintenance and Health Promotion
Stress and the Elderly
Drug-Related Problems in the Elderly
Alcohol-Related Problems in the Elderly
Self-Care and Mutual Help
Older Americans as a Resource in Health Maintenance and Health Promotion
Health Education

3. Special Issues in Health Maintenance and Health Promotion

Special Populations of the Elderly (Rural, Minority, and Women)
Research on Health Maintenance and Health Promotion

IV. KEY FINDINGS

A. The Physical and Social Environments

Health maintenance is an adaptive balance between the individual and the environment. Therefore, a failure in health maintenance in an older person should not be viewed simply as the result of intrinsic individual weakness or disability, but also as a result of thwarting influences in the environment.

Factors in the physical environment include adequate housing and transportation, barrier-free designs, pollution control, and accessible health and social services. Of importance in the social environment are the family and neighborhood networks, which provide needed supports and links to social and health services for health maintenance. Supportive social environments also include constructive attitudes in elderly individuals, their families, and society as a whole that favor the principles of health maintenance and health promotion.

While there is no evidence that physical activity prolongs life, there is evidence that it promotes fewer years of disability. According to some authors, physical activity can bring about a two-thirds reduction in the number of individuals unable to care for themselves because of physiological aging, reduce mental illness by 10 percent

through decreased anxiety and elevated mood, extend the period of independence by several years, and substantially reduce the number of people requiring residential care. Activity also promotes increased mobility in the elderly and thus serves as a deterrent to major chronic disease and accidents.

The informal network of family and friends—the social support system—contributes to the mental and physical well-being of older persons. Without adequate backup from responsive health and social service networks, however, there is a danger of premature institutionalization. It has been estimated that half of nursing home residents are inappropriately placed because of lack of appropriate review services.

B. Indicators of Change in Physical and Mental Health in Late Life

To attribute the complaint of poor physical health to "old age" often places it forever in the category of irreversible and untreatable problems. Although normal aging involves gradual decline in function, the decline does not typically lead to functional disability. However, an older person may not have adequate functional reserves, and even a brief acute illness can stress the body or mind beyond the ability to compensate. Often the indicators of developing physical illness will be the same as those arising from a change in a person's mental, social, or nutritional condition. The mental health of an older person, for example, is frequently impaired by somatic illness.

Early identification of the high-risk elderly is important to prevent health conditions from deteriorating significantly before being brought to full medical attention. This is especially important for those who live alone or are otherwise socially isolated, the very old and frail elderly, and those with medical problems who are receiving multiple medications.

C. Rehabilitation

Rehabilitative measures should not be regarded as secondary to medical treatment but as essential first components of service in medical, surgical, and psychiatric practice. At all stages in the life of elderly persons, the goal is to provide normal independent living. The current high cost of providing such services to Americans through hospitals and nursing homes could be alleviated by developing extensive, coordinated community-based services.

Enormous new demands will be made on rehabilitation services as a result of such advances as organ transplantation, electronic sensory implants for deafness, and other developments. Rehabilitation services should be provided as an integral and major part of customary health services in the total spectrum of medical care in hospitals, at home, and on an outpatient basis in the community.

D. Mental Health

It has been estimated that only 10-20 percent of the more than 4.5 million older persons who need or could benefit from mental health services actually receive such care. The Mental Health Systems Act (P.L. 96-398) in 1980 authorized $105 million for mental health services for populations now underserved. Although 40 percent of these grants must be spent on services for the elderly, up to this time it is estimated that the Community Mental Health Centers authorized by the Act have utilized only 4 percent of their funds for services to that group.

Inappropriate diagnoses (e.g., senility) or lack of appropriate resources in communities have led to a high rage of institutionalization in public mental health hospitals; 30 percent of patients in those institutions are over age 65. To a significant degree, the poor response of public service delivery systems to older persons with mental disorders is due to a lack of geriatric information in the training curriculums of the health professions. Baseline data are needed on the health status and social functioning of the elderly, the ability to recognize onset of mental dysfunction, and provision of social and family supports in the community to keep older persons at their highest level of functioning. Self-help programs can ameliorate the effects of mental illness as well as prepare persons for stresses and losses that produce symptoms of mental illness.

E. Dental Health

The elderly have a far greater need for dental services than the general population, but their use of such services is disturbingly low. Part of the problem lies in the attitude of the elderly themselves who do not see the need for continued dental care. Other factors include lack of funds to purchase dental care or appliances, the exclusion of dental coverage under the major public and private health plans, and limited access to dental care through problems with transportation and mobility.

There is a critical need for new knowledge in geriatric dentistry, including the physiology of aging and information to define optimal oral health for the elderly. So little is known about the oral health status of the elderly that it is impossible to assess differences among various ethnic groups and geographic areas. There also is a need to understand the practical considerations that would facilitate the delivery of dental services to the elderly, including transportation, physical access to buildings, and funding by such systems as Medicare and Medicaid.

F. Needed Linkages for Services for the Elderly

Medicare has provided considerable service in institutional care, but continues to provide little in terms of in-home benefits. Although in-home care benefits have now been liberalized under Medicare, important services for the elderly such as nutrition

services, homemaking and chore services, legal services, transportation, some health-related therapies, medication, special housing allowances, most dental care, and visual and auditory services are not covered. Medicaid, available to the elderly poor, provides for some of those services but since this is at the option of the States, benefits vary in different geographic locations. Title XX of the Social Security Act provides some of these services, but also at the option of the States. The Older Americans Act seeks to bring about coordinated service delivery and allows contracting for some of the above services for the elderly. However, fragmentation of services is still the rule.

G. Nutrition

Adequate nutrition is seen as the most important factor in improving the health status of the elderly in the 1980s and a prime intervention in health maintenance and health promotion. Although there has been growing interest in food and nutrition programs for the elderly at the Federal level, there is a marked lack of interest in well-designed, well-conducted nutrition education programs that deal with scientific facts rather than generalizations. Surveys of elderly shoppers by the Food and Drug Administration and the Department of Agriculture show that they are the least informed about food value, the most unaware of food labeling, and have the least understanding of nutrition information on labels.

There is limited research on nutrient requirements as people grow older. Since nutrients are closely related to calories, calorie sources must be chosen correctly to provide enough nutrients. Chronic diseases and inadequate dentition can dispose individuals to faulty nutrition.

At the Federal level, food and nutrition programs are carried out through the Older Americans Act, which during 1979 provided congregate meals at more than 10,000 sites for an estimated 160.1 million meals. Other major Federal food programs are conducted by the U.S. Department of Agriculture, which provides commodities and administers the Food Stamp Program. In addition, numerous food and nutrition programs are carried on by volunteer agencies at the local level.

Although nutrition education along with meal service was an important part of the Older Americans Act Program at its inception, a recent study found that the Program's nutrition education activities have been conducted sporadically, with limited personnel, and often entirely with Federal funds. Nutrition knowledge, though vital in health maintenance, has competed unfavorably with other social services under the Older Americans Act. A major failure of nutrition education programs is that nutrition is taught at an academic level and little effort is made to find out what individuals want to know. In order to know what to teach the elderly, it is important to involve them in the planning phases of nutrition education programs.

H. Stress

Modern research has demonstrated that stress is a major predisposing factor in virtually all diseases. Although the proximate cause of illness may be a specific diagnostic entity, it is usually stress that paves the way. Nevertheless, a narrow and negative view that all stress is harmful has led much of the elderly population to believe that stress automatically shortens life and that they should "take it easy." Actually, a certain amount of stress is beneficial because it is stimulating and adds zest and creativity to life. The goal should not be to eliminate stress but to help the elderly cope with it directly and use it creatively.

Though many stresses arise from personal situations, some stresses in the elderly arise from broader societal causes such as inadequate income, unsafe environments, and a socially imposed sense of uselessness. Other stresses arise from relocation, serious or prolonged illness, death of loved ones, and social isolation. Elderly persons can be taught techniques to cope with stress, including identification of stressors, decision-making and communication skills, assertiveness, relaxation, and meditation. Control of stress by these means can often lessen reliance on drugs and alcohol. Self-help and mutual support activities may be a promising way to teach stress management techniques to the elderly.

I. Drug Use and Misuse

The elderly consume more prescription and over-the-counter drugs than any other group and are particularly susceptible to drug advertising that promises a chemical solution to stress or illness. Many older persons living on fixed incomes frequently turn to over-the-counter preparations and home remedies to avoid the cost of seeing a physician.

Since 86 percent of persons over age 65 have one or more chronic conditions, treatment of older persons is likely to involve a variety of powerful drugs that may produce complex actions that the elderly do not understand. Although the aged account for an increasing proportion of therapeutic drug use, the safety of most drugs has been evaluated in younger patients. Research in geriatric pharmacology is limited, and little is known about altered patterns of drug metabolism and toxic reactions in the elderly. Often drug reactions may be mistaken for mental illness.

J. Alcohol Use and Misuse

The severity of alcohol problems in older alcoholics is less than in younger persons. It is estimated that as many as 1.6 million elderly persons over 65 may be alcoholic. The problems and needs of older problem drinkers have been largely ignored by service agencies and researchers.

Elderly alcoholics are more likely to drink daily, at home, and alone. For several reasons, excessive alcohol use in the elderly is especially likely to cause severe illness: it strains body systems that are in a general state of metabolic change; it interferes with proper nutrition; it can interact with prescription and over-the-counter drugs; and the anesthetic effect of alcohol can mask warning signals of illness.

Older alcohol abusers are not as likely to have the deep-seated psychological problems of younger alcohol abusers. Their problems are more related to situational factors and therefore easier to confront. The concern of the elderly about their health status is the most positive tool for treatment and subsequent recovery.

K. Self-Care and Mutual Help

The potential for self-care and mutual help is among the most promising developments in health maintenance and health promotion for the elderly. However, there has been little reference to the health care concerns of older persons in the self-care literature except for the subject of menopause. There is a need to train both the elderly and the professionals who help them in the principles of self-care, with emphasis on nutrition, physical fitness through regular exercise, rehabilitation, installation of furniture and barrier-free designs appropriate to older persons, and social and occupational therapy.

Physical fitness is an especially important component of self-care in the later years. As stated above in the section on The Physical and Social Environment, regular exercise by the elderly can shorten the period of disability, increase the number of years of independence, and promote mental well-being. The elderly, however, tend to underestimate their own physical abilities and capabilities and tend to believe that the need for exercise diminishes and eventually disappears with age, that vigorous exercise after middle-age is risky, and that sporadic exercises are sufficient. A 1975 amendment to the Older Americans Act directs the Administration on Aging to encourage the development of services designed to help older Americans obtain and maintain well-being through programs of regular physical activity and exercise. Such services should be provided in a variety of settings that provide a social context, including mutual help groups.

Participation in self-care classes can often reduce unnecessary and costly reliance on health professionals and provides an opportunity to develop social ties with others who share common concerns and interests. Groups share the common goal of increasing the involvement of their members in decisionmaking and treatment concerning their health. The value of self-care in the health area is illustrated by existing self-management programs in arthritis, diabetes, and cancer prevention. Other mutual help groups with potential for older persons are those concerned with medication safety, nutritional habits, support for the bereaved, grief control, physical fitness, and mental health problems.

L. Older Americans as a Resource in Health Maintenance and Health Promotion

The utilization of the skills, talents, and resources of older Americans is a major health maintenance and health promotion effort that our country can endorse. Prevention can most effectively be carried out by utilizing the elderly themselves in self-care programs. A sense of uselessness that can arise from the disruption of long-established work patterns can be translated into either paid or voluntary employment past the so-called "retirement age." Retirement can offer a variety of options to older Americans, including the choice of being active or inactive. The mental health of older persons can be enhanced by their continued involvement in the mainstream of society.

M. Health Education and the Older Population

A multifaceted and multidisciplinary approach to health education that seeks to help individuals make informed choices about their health is a necessary component of all health maintenance and health promotion programs. There are at least three targeted populations for health education of the elderly: older persons themselves, the health care system, and the general population. Though the health care system provides the most feasible environment for health education, one of the greatest obstacles in health education for the elderly at this time is the lack of interest in the elderly on the part of health professionals. It is very possible that providers other than physicians are best suited for developing and implementing new education strategies. Another obstacle is the pervasive negative attitude of society toward the elderly.

V. SPECIAL CONSIDERATIONS

A. Special Populations

Research on elderly minorities has been notoriously negligible in the past. Their numbers and needs have not been adequately defined, although it is well known that they are generally poorer and have lower life expectancy than their white counterparts. Native Americans generally have more health problems than other minorities. Educational and linguistic barriers contribute to lack of knowledge of self-care and inhibit access to service for blacks, Hispanics, Asian Americans, and Native Americans. The attitudes of caregivers often constitute a further barrier and should be remedied by educational efforts designed to sensitize them to the needs and problems of minorities.

Contrary to popular belief, rural populations are not homogeneous and their elderly face some of the problems that minority elderly do: low income, inadequate housing and transportation, and physical and psychosocial isolation. In view of a lack of an

adequate variety of services and poor access to existing services, it is not surprising that the rural elderly generally are in poorer health than their urban counterparts.

The health needs of the growing population of elderly women (women outlive men by an average of 8 years) require special attention. Women are three times more likely than men to reside in nursing homes. A very large percentage (77 percent) of those who suffer from chronic disability are women. Problems particular to older women are osteoporosis (occurring three to five times as often among women), breast cancer (the leading cause of death for women 40 to 60 years of age) and high consumption of tranquilizers and antidepressants. Since a large proportion of elderly women live alone, they are especially vulnerable to drug and alcohol use resulting from loneliness and stress. Few single women possess the economic resources for adequate health insurance coverage and access to quality mental health treatment programs. New forms of primary care are help efforts, health monitoring programs, and alternative therapies. Special research also is needed to define the health problems and needs of older women.

B. Research in Health Maintenance and Health Promotion

Research is needed in the area of health maintenance and health promotion to more clearly define the elderly population in the United States, identify the needs of the elderly with reduced function or chronic disease, and develop programs to maintain and enhance the productivity of the elderly.

VI. KEY ISSUES IDENTIFIED IN THE COMMITTEE'S REPORT

It is important to regard health maintenance and health promotion in the context of the Older Americans Act, which established the White House Conference on Aging. Title II states:

> "...The Congress finds...that there is a great need to make comprehensive and quality health care more readily available to older individuals."

Although two other Technical Committees, Health Services and Long-Term Care, established findings and recommendations within this overall mandate of the Act, the Technical Committee on Health Maintenance and Health Promotion finds that there are certain broad issues in the provision of health for older individuals that overlap all the Technical Committees. Prominent among them are the following.

Should the health care system emphasize illness, or wellness?

The bulk of America's health care expenditures go toward curing rather than caring. A pervasive negative cultural stereotype is that all older people are sick, feeble, frail, and vulnerable. It is assumed that old people are at "the end of the

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line" and therefore not worthy of either the investment of public money or the time of medical professionals. Although the bulk of the elderly population report one or more chronic disabilities, for the most part those are not problems that severely limit their activities. It must be remembered that about 80 percent of the elderly are mobile and self-sufficient and that only 10 percent are functionally disabled, either mentally or physically.

Should the emphasis be on acute care, or on preventive care?

Community and social institutions have not dealt well with the elderly in assessing the needs for supportive mechanisms to prevent acute illness. Usually the onset of disease is the point of entry of an older person into the health care system. Part of this has to do with economy, income, and the attitudes of the elderly themselves toward proper health maintenance habits. The other incentive to receiving only acute care is that our society pays for that kind of care through its Medicare system. As a result, expenditures have mounted steadily.

Should the emphasis be on institutional care, or on in-home supports?

Despite lip service paid to maintaining the elderly in their own homes and communities and preserving independence and freedom of movement, the major health care support systems in the United States (Medicare and Medicaid) favor institutional care by providing the bulk of expenditures for hospitalization and physicians' fees associated with hospitalization. Only very recently (within the past several months) have Medicare benefits been liberalized to include more visits of home-health-care professionals to help prevent unnecessary institutionalization. This, however, is a small step in providing preventive services to the elderly. There are many more supports yet to be accepted that would provide a floor for maintenance in the community. Chief among them are housing assistance, accessible transportation, nutrition services, chore services, certain rehabilitative counseling, mental health services, drug and alcohol counseling, and dental services.

What can be done to make health care systems more accessible?

A variety of specialized services have developed over the past decade, each with separate eligibility requirements, range of services, and funding mechanisms but with many duplications of service. As a result, older persons are subjected to confusion and dismay about the services they need and are entitled to—about having to go to "15 sources for one cure." The present maze of programs in the health delivery system for older Americans is best summed up this way: it is no system at all.

VII. RECOMMENDATIONS

A. Adequate Income

Several observers have noted the role of poverty in many of the malnutrition and related problems seen in the elderly. These problems are being severely exacerbated by the current inflation. Adequacy of income should be a primary factor in any consideration of measures designed to improve the overall health status of the elderly. Existing measures of poverty level income fail to provide for even a minimally adequate standard of living for the elderly and should be revised.

Action to be Taken

- Existing measures of poverty level income should be revised to reflect current economic conditions.
- All older Americans should be guaranteed a minimum adequate level of income to maintain a decent standard of living.

B. Nutrition Education

It is recommended that a nutrition education and outreach program be established for all persons over 60 years of age and that it be a cooperative venture planned and supported mutually by Federal, State, and local governments as well as by the private sector.

Action to be Taken

- Priorities within the Older Americans Act of 1965, amended as of 1978, should be reordered to strengthen the nutrition education aspects of the Act as a long term preventive measure. The Committee believes this change in emphasis would have far-reaching benefits, especially in times of decreased economic resources to all older Americans. (This would require a reordering of spending priorities.)
- Coordination of activities between various Federal agencies involved in nutrition education (Administration on Aging, U.S. Department of Agriculture, Food and Drug Administration, Public Health Service) has been inadequate to have significant impact. The existing coordinating committee for these agencies should be activated and strengthened to administer a common program in nutrition education. The coordinating committee should also involve outside deliverers of nutrition education services to stimulate further developments in the private sector.

- Further research should be conducted on the nutrient requirements of older persons in order to plan effective educational approaches.

- The media have a responsibility to include the elderly as a special group in programs dealing with consumer protection. Special television programming is needed to deal with older persons' need of nutrition knowledge.

C. Dental Health

Oral health must be an important constituent of total continuous health care. Preventive dental education and research should be directed to overcoming misconceptions and apathetic attitudes among elderly persons.

The dental profession should promote programs in dental health education and support dental public health assessment services for the elderly.

Action to be Taken

- Dental care must be provided under Medicare.

D. Assessment Centers

A system of health assessment centers is recommended for all persons over age 60. The purpose of these centers would be to provide preventive health care for maintaining health and independence. They would serve as focal points where comprehensive, multidisciplinary health assessment would be provided on-site or by referral. Assessment centers would manage chronic diseases, provide individual and group instruction and nutrition counseling, provide outreach to minority and rural populations, and perform service such as case management and linkage to existing services. This recommendation does not presume the establishment of a separate health system for the elderly. It would rely on existing Federal, State, and local coalition funding for implementation. Services would be located within existing hospitals, community health clinics, community mental health clinics, senior centers, the facilities of community groups and clubs, storefront facilities, and other places.

Action to be Taken

- If the lead for coordinating such a system is taken by the Area Agencies on Aging (the local coordinating mechanism for services to the elderly), additional allocations must be made available for staff.

- Existing community health services facilities and staff should be heavily

utilized for the assessment centers through interagency and cooperative agreements with other Federal levels.

- Information from demonstration programs through long-term care channeling projects and other in-home service demonstration models of the Department of Health and Human Services should be incorporated in program design.

- The services of the National Senior Health Services Corps should be an integral part of this service delivery system (see the section on Older Americans as a National Resource, below).

E. Self-Care and Mutual Help

It is recommended that the growth of self-help and mutual care groups at the community level be accelerated through efforts in the private and public sectors. With very little expenditure of funds, this mechanism can help prevent unnecessary physical and mental deterioration in old age. Central to this recommendation is the creation of support groups for disease-monitoring, physical fitness, discussion to alleviate stress and socialization problems, and recovery from alcohol and drug abuse. Families have a key role to play in self-help and should be given tax incentives to care for their elderly. The Committee sees enormous potential in this recommendation for the prevention and alleviation of institutionalization.

Action to be Taken

- Private organizations should provide a lead role. Some effort has been made in this direction by the senior center network.

- The Administration on Aging, through model and demonstration funds, should provide funding in fiscal year 1982 to test the validity of several models of self-help and self-care.

- Alternatives to home ownership, featuring congregate housing with supportive services and low cost rehabilitation of nonresidential buildings, should be pursued.

F. Older Americans as a National Resource

It is recommended that a National Senior Health Corps be created to utilize older Americans in the area of health maintenance and health promotion. This group would be distinguished from in-home health providers in that it would serve primarily in health education, counseling, and outreach. The goal of the program would be to bring out basic self-help mechanisms in the older population, promote

older persons as a peer resource, and establish a paraprofessional group as part of the health team.

Action to be Taken

- Participants should be provided an initial three to six months of instruction in gerontology under curriculums to be established in institutions of higher learning.

- It is recommended that several demonstration projects be established to test the validity of this concept and provide operational guidelines for the National Senior Health Corps.

G. Medicare Act Improvements

It is recommended that the Medicare and Medicaid Acts be amended to cover the expense of necessary health maintenance and health promotion services for older Americans, for example, the costs of outpatient prescription drugs, dental care, eye care, hearing aids and examinations, and health assessment. These costs, prohibitive to many older Americans, force priority spending of their budgets at the expense of other important needs such as proper nutrition and housing. Existing biases that favor institutional and acute care over support for ambulatory and community-residing Americans should be eliminated.

Action to be Taken

- Medicare legislation to begin a health maintenance and promotion floor for older Americans (which has previously been introduced and will be reintroduced as the Medicare Improvements Act in 1981) should be passed.

- Disincentives to utilizing Medicare for preventive health maintenance and health promotion (e.g., deductibles and coinsurance requirements) should be removed.

the 1981
White House
Conference
on
Aging

Executive Summary of Technical Committee on HEALTH SERVICES

NOTE: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging, or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

EXECUTIVE SUMMARY

I. INTRODUCTION

The health experiences of older persons differ considerably from those of other segments of the adult population. Furthermore, the health problems faced by elderly persons today will likely become worse over the next decade as their numbers grow and the resources available to meet these needs shrink. We offer first a list of some of the major problems regarding health services for the elderly in the country and then a set of recommendations designed to address, but not necessarily to redress, the many deficiencies in health care suffered by the aged in this country. The reader is reminded that a fuller discussion of both the problems and the recommendations is available in the parent report from this committee.

II. MAJOR FINDINGS

A. Health Maintenance.

Most of the elderly, especially the "young-old" (age 65 to 74), are relatively healthy and are primarily concerned with maintaining their health.

B. Chronic Illness

Older persons who do become ill are likely to have a mixture of both acute and chronic illnesses and disabilities, in contrast to younger adults, who usually have only single acute illnesses. The multiple illnesses affect multiple organ systems simultaneously, and treatment of one disorder may provoke malfunction in another organ system or aggravate a coexisting disease. The older person with multiple diseases is therefore at greater risk of experiencing over or undertreatment or of having a treatment "misadventure." In addition, the older person frequently does not know precisely where to go for health care services.

In older persons and in the young, manifestations of both acute and chronic illnesses may differ for the same diseases, leading to potential delay and potential misdiagnosis rather than to timely and appropriate treatment and rehabilitation.

Medications used in the treatment of both physical and mental disorders have significantly altered effects in older patients, who often require multiple medications. Drug interactions and adverse drug reactions add to the health care burdens of an already burdened segment of the population.

As currently designed, the health care system does not reach out to older people and inform them how the system can serve them. Thus, elderly persons often do not know where to turn for help, what to look for, or what services they are eligible for. They have no simple way of evaluating the quality of the services they receive.

C. Mental Illness.

Fifteen percent of all older people living in the community and an astonishing 50 to 70 percent of elderly living in institutions suffer from serious mental and/or emotional problems. Mental disorders may be the principal cause of disability among the elderly or they may complicate the health status of those elderly with major physical problems. Mental problems common among the elderly include depression, anxiety states, paranoia, and alcoholism, as well as reversible and irreversible dementias, i.e., serious intellectual and memory disorders. The frequency of suicide, especially among males, greatly exceeds rates experienced by younger persons.

D. Multiple Impairments.

Older persons experiencing health and mental health problems frequently have associated disabilities and impairments including social isolation and financial deprivation. Impairments in these additional areas of functioning can determine whether an individual with physical or mental disorders remains in an independent community setting, or whether he or she must be admitted to an institutional long-term care setting.

E. Demographic Characteristics.

Individual health needs vary greatly but recognized demographic variables, including age, sex, race, income, location, family status, and living arrangements can at least partially help to predict needs. Age is a major factor influencing entry into a nursing home. Sex has now replaced race as the major single factor influencing life expectancy.

F. Manpower.

Major portions of the health care systems in the United States are oriented toward acute illness and the practice of specialty and subspecialty medicine. While these elements are highly developed and may meet some of the health care needs of the elderly, the basic approach does not respond to the regularly expected health care experience of the old. The elderly lack primary medical care. Individuals requiring multiple types of health care services often find such services disarticulated and in separate sections of their communities. Continuity of care is difficult to achieve.

Whereas younger patients with acute illness can find health care providers interested in their problems, elderly patients with their complex health, mental health, social, and economic problems encounter substantial difficulty locating health care providers with the requisite attitudes, interests, knowledge, and skills.

G. Prevention.

There is increasing recognition of the need for preventive programs and services, especially with respect to chronic disease and accidents.

H. Death.

For the dying patient, humane terminal care is often the most pressing need, and it is usually difficult to meet.

I. Medicare.

For most people over age 65, the Medicare experience has been, on the whole, positive. Coverage of acute hospital care is good, of physicians' services, fair. Major deficiencies relate to costs—both to the individual and to society—and to failure to cover preventive and long-term care. This omission has an effect on health and contributes both to the ever-increasing fragmentation of services and to the unacceptable rise in costs. Medicare urgently needs reform.

J. Minorities.

Just as the health experiences of the elderly differ from those of the young, so do the health experiences of the minority elderly, especially of black, Hispanic, or American Indian elderly, differ from those of the majority elderly. Certain elements of the health care system meet their needs even less well than they do those of majority elderly. Thus, some minority elderly will experience age-related health problems and may, in fact, die before attaining the age at which they become eligible for Medicare. In addition, many more minority elderly do not have Medicare and/or Social Security benefits available to them at age 65 due to low earnings during their working years. Limited availability of health care personnel sensitive to language requirements, customs, and social needs of ethnic minorities compounds the problems.

III. RECOMMENDATIONS

A. Useful Work.

Because physical and mental activity and social involvement are essential to health, the older individual should be encouraged to remain active as long as possible. Public and private institutional arrangements should be adjusted to this end.

B. Primary Care.

Each elderly individual should have access to a single source of good primary care. Such care should emphasize responsible and continuing surveillance by a primary-

care practitioner, usually a family physician, general internist, or a nurse practitioner or physician's assistant. Periodic preventive services, referral to specialized services (from both physicians and allied health care professionals), long-term and terminal care, and centralized comprehensive medical records are essential components of such primary care.

C. Allied Health Professionals.

Each elderly individual should be eligible under Medicare coverage up to a fixed amount for drugs and the services of the major allied health professions. Such services should include dentistry; vision; hearing; foot care; nutrition, family and personal health counseling; and the services of the various rehabilitation therapists.

D. Medicare Reforms.

Title XVIII of the Social Security Act should be amended to carry out the following changes:

1. Recognize the essential role of primary care, including preventive health services and long-term care, in the health of the elderly; make appropriate administrative arrangements to assure such care, including non-discriminatory reimbursement of providers; repeal the requirement for onsite physician supervision of other approved primary-care practitioners.
2. Repeal those provisions of Sec. 1862 that prohibit payment for preventive services and for "orthopedic shoes or other supportive devices for the feet"; provide reimbursement for a defined schedule of periodic, age-specific preventive services; create a defined list of preventive, maintenance, and rehabilitation services to be provided by the allied health professions (with reasonable cost-sharing).
3. Increase immediately the ceiling for outpatient psychiatric benefits from an annual maximum of $250 to $1000 and increase from 50 percent to 80 percent Medicare coverage for these services; establish a series of demonstration projects to determine the feasibility of covering mental illness on the same basis as physical illness.
4. Establish a limit on cost-sharing for those few patients who have to remain in a hospital more than 60 days or whose combined deductible and coinsurance come to more than $1000 in one year.
5. Repeal the provision of Sec. 1862 that prohibits reimbursement for the ill-defined term "custodial care"; recognize the need for continuity between acute and long-term care (both institutional and home-based) and provide Medicare reimbursement (rather than Medicaid) for appropriate long-term care in both types of settings, as determined by the Long-Term Care Assessment and Case-Management Program set forth in Recommendation E; establish conditions of Medicare participation for providers of long-term care (both institutional and home-based) and appropriate cost-sharing formulas between Medicare and long-term care patients; provide for transfer from Medicaid to Medicare of any outstanding federal funds now budgeted for long-term care under Medicaid.

6. Shift from retroactive "reasonable costs" reimbursement to negotiated prospective rates as the basis for payment to institutions and from retroactive "reasonable charges" based on CPR criteria to negotiated prospective rates as the basis for payment to practitioners; require that practitioners elect annually between "participating" and nonparticipating" status so that beneficiaries can know in advance the percentage of co-payment involved.

E. Long-Term Care Coordinating Service.

A new service to coordinate long-term care for the elderly and disabled on a community basis should be established as Title XXI of the Social Security Act.

F. Humane Terminal Care.

Humane terminal care should be considered a natural and essential aspect of good health care for the elderly. Appropriate legal, medical, and organizational arrangements should be made to translate this ethical concern into regular medical care.

G. Professional Training in Geriatrics/Gerontology.

The rapidly growing consensus about the need for more physicians, nurses, social workers, and other professionals and paraprofessionals with special training in and commitment to geriatrics/gerontology, should be promoted and supported by adequate public and private funds for such training, and by appropriate adjustment of licensing laws and certification requirements. Particular attention should be directed to the training of minority health professionals.

H. Research in Geriatrics/Gerontology.

Research on the problems of delivering more effective care to the elderly must have more support. Health services research and clinical/epidemiologic information are sorely needed in a number of vital areas.

HEALTHY PEOPLE

The Surgeon General's Report On Health Promotion And Disease Prevention

1979

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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CHAPTER 7

HEALTHY OLDER ADULTS

Goal: To improve the health and quality of life for older adults and, by 1990, to reduce the average annual number of days of restricted activity due to acute and chronic conditions by 20 percent, to fewer than 30 days per year for people aged 65 and older.

If longer life has been one of society's most conspicuous accomplishments, there is compelling need now for another: a better, healthier life for older people.

More Americans today live to older age than ever before. Whereas in 1900 there were only three million Americans aged 65 and over, making up four percent of the population, now there are 24 million, composing 11 percent. By the year 2030, people 65 and over will number 50 million and comprise 17 percent of our population.

The death rate for older Americans compares well with that for older citizens of other countries, although we still rank behind countries such as Japan and Iceland (Figure 7-B). For all Americans over 65 the death rate is down from about 8,300 per 100,000 in 1900 to about 5,400 in 1977 (Figure 7-A). And for those 65 to 74, it has been amost halved— from 5,600 per 100,000 in 1900 to 3,100 in 1977.

But we have cause for concern.

The reasons for considering age 65 as marking the start of old age are mostly social, rather than biological. Aging is a subtle, gradual, lifetime process and there are startling contrasts in how individuals age. Even within an individual, different body systems age at different rates.

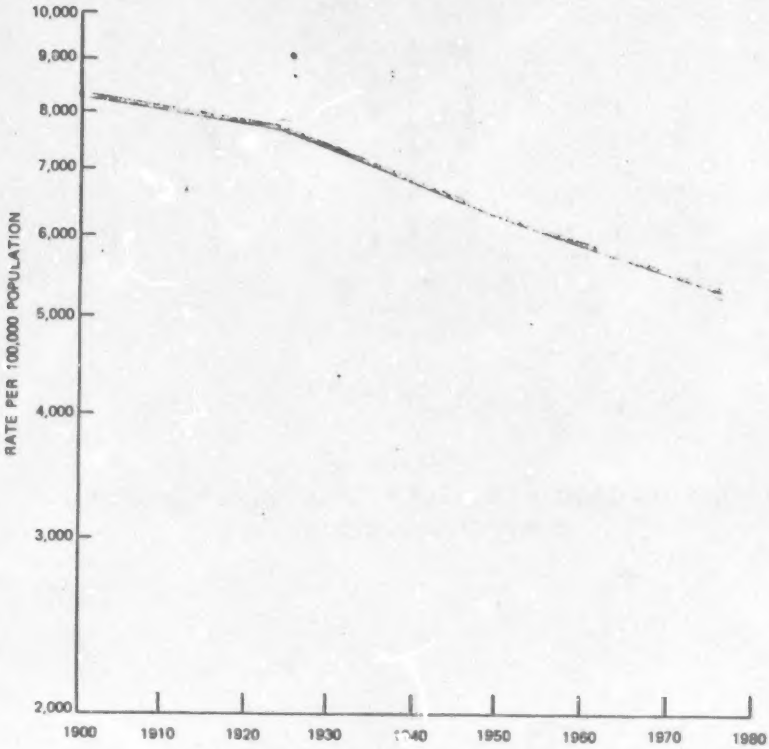
In short, age 65 does not mark the start of any inevitable uniform decline in physical and psychological functioning.

Nevertheless, the proportion of people with health problems increases with age and, as a group, the elderly are more likely than younger persons to suffer from multiple, chronic, and often disabling conditions.

Eighty percent of our older people have one or more chronic conditions and their medical treatment accounts for about 30 percent of the Nation's health care expenditures.

The long-term goal of a health promotion and disease prevention strategy for our older people must not only be to achieve further increases in longevity, but also to allow each individual to seek an independent and rewarding life in old age, unlimited by many health problems that are within his or her capacity to control.

FIGURE 7-A
DEATH RATES FOR AGES 65 YEARS AND OVER: UNITED STATES, SELECTED YEARS 1900-1977

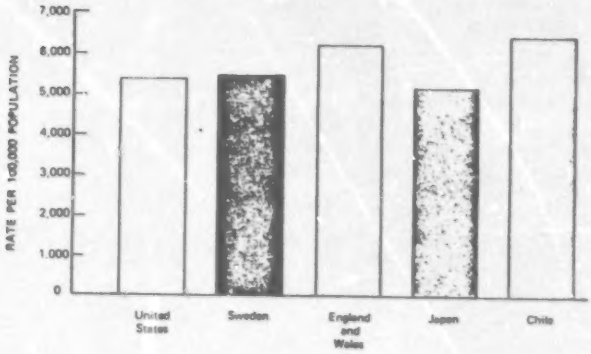


NOTE: 1977 data are provisional; data for all other years are final. Selected years are 1900, 1925, 1950, 1977.

Source: National Center for Health Statistics, Division of Vital Statistics.

FIGURE 7-B

DEATH RATES FOR AGE 65 YEARS AND OVER: SELECTED COUNTRIES, 1975

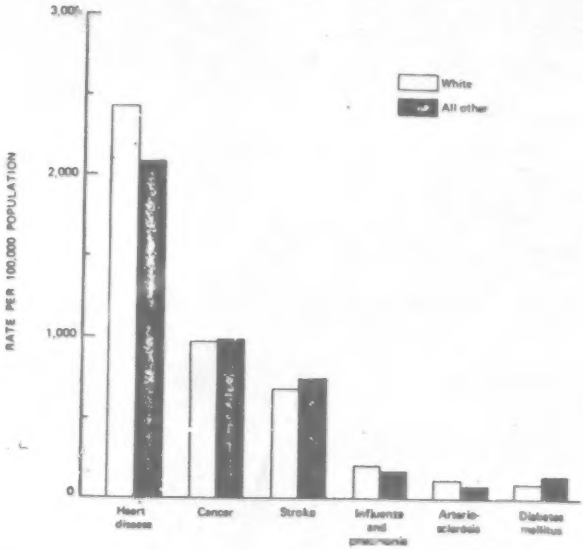


NOTE: The most recent year of data for Chile is 1971.

Sources: United States, National Center for Health Statistics, Division of Vital Statistics; other countries, United Nations.

FIGURE 7-C

MAJOR CAUSES OF DEATH FOR AGES 65 YEARS AND OVER: UNITED STATES, 1976



Source: Based on data from the National Center for Health Statistics, Division of Vital Statistics.

"Quality of life" is a phrase sometimes used to describe the latter goal. It is not something readily measured—but activity limitations due to illness or injury clearly compromise the quality of an older person's life.

Over the last decade, the proportion of people over 65 who have had to place limits on themselves, primarily because of chronic conditions, has fluctuated between an estimated 42 and 47 percent—only slightly less than half the 24 million elderly.

And the average number of days of limitation has changed little in recent years, ranging from 31 to 38 days per person per year.

But a large portion of chronic activity limitation stems from respiratory conditions such as chronic bronchitis and emphysema. Reductions in cigarette smoking among adults should lower the incidence of these conditions by 1990.

Moreover, a relatively small reduction in the incidence of strokes or a significant increase in persons protected from influenza and its complications could produce a noticeable reduction in activity limitation.

There is much that can and should be done to help make older Americans healthier and better able to function independently.

Subgoal: Increasing the Number of Older Adults Who Can Function Independently

As do younger people, older Americans hope for a state of well-being which would allow them to perform at their highest functional capacity on physical, psychological, and social levels.

Their greatest fear is of being helpless, useless, sick, or unable to care for themselves.

Despite a common misconception, most elderly Americans can and do remain in their own homes. In 1975, 77 percent had their own households—51 percent living with a spouse, 26 percent living alone—and 18 percent lived with someone other than a spouse. Only five percent lived in institutions.

Although the majority of the elderly are vigorous and completely independent, there are 45 percent with certain activity limitations—some associated with mental disabilities, but most due to physical handicaps caused by heart conditions, arthritis and rheumatism, hearing loss, and visual impairments.

Up to 20 percent of older people—from one-third to one-half of those with any activity limitations— are handicapped in ability to move about freely, compared with two or three percent of the 17 to 64 year old population.

Yet it must be reemphasized that only five percent reside in institutions—and many of these are temporary residents who are recovering from illness and will return to the community.

With adequate social and health services, a greater proportion of the elderly could maintain a relatively independent lifestyle and vastly improve the quality of their lives.

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Disease-Related Factors of Dependency

Severe physical and mental decline in older people is not inevitable. While some changes with age are normal, many others can be avoided.

Although about half of the Nation's nearly one million elderly living in long-term care institutions are there because they were diagnosed as senile, that diagnosis is not always justified.

A mistaken diagnosis may be made because physicians and families may attribute mental decline and behavioral changes associated with physical conditions to senility, and fail to initiate appropriate and timely treatment.

Among the many causes of apparent senility which can be treated to reverse the condition are drug interactions, depression, metabolic disorders (thyroid, kidney, liver, and pituitary malfunction, as well as hypercalcemia and Cushing's Syndrome), chronic subdural hematoma, certain tumors, alcohol toxicities, chemical intoxications (arsenic and mercury), nutritional deficiencies, sensory deprivation due to social isolation or failing sight or hearing, chronic infections, hypoxia or hypercapnia associated with chronic lung disease, and anemia.

So numerous are the reversible causes of mental impairment that comprehensive diagnostic evaluation is often indicated. Moreover, there is growing consensus among authorities that even with irreversible organic brain syndrome measures are available to lessen patient discomfort, to slow or arrest deterioration, and to help the patient make use of residual strengths.

Emphasis needs to be given, too, to the potentially adverse effects of the many and varied drugs prescribed for the elderly. Surveys indicate that older people often have more medications prescribed for them than really needed—a danger which is frequently overlooked.

Evidence is accumulating to show that in older people the body's handling of drugs is quite different compared with the younger adults on whom drug clinical trials are usually performed. Moreover, the elderly, often suffering from multiple chronic diseases, follow complicated drug regimens that can lead to unanticipated drug interactions.

The mental confusion, and other untoward effects on physical health caused by drugs and drug interactions, can be minimized if older people have access to a continuing, well-informed source of medical care, with proper attention given to provision of only needed and suitable drugs and to patient education about drugs and drug effects.

At some point, too, elderly people are likely to need health or social system support because of social isolation, a dramatic change in their lives such as retirement, loss of a spouse, reduced income, or disease or injury.

Among the most frequent chronic conditions and impairments for older people in the community are: arthritis, which affects 44 percent of those over 65; reduced vision, 22 percent; hearing impairments, 29 percent; heart conditions, 20 percent; and hypertension, 35 percent. The elderly also, regardless of whether they are chronically limited in activity or mobility, are subject to an average of 5.5 weeks of short-term restricted activity a year. One third of this results from acute illnesses

or injuries. Some acute episodes, such as burns, falls, or influenza and pneumonia, may be preventable.

Although most of the elderly are able to assess their own health status quite reliably, they may not always seek needed attention promptly. The problem may be due in part to unavailability of needed services, especially in rural communities. But it may also be related to fatalism, fear of confinement, poor transportation, or economic factors.

Communities would do well to develop outreach programs to find the sick and disabled in this population and help them quickly—when help can be most effective as well as most economical.

The potential of such programs has been demonstrated in a four-year study in Texas: the average number of short stay hospital days for mental illness patients 65 and over was reduced from 111 to 53 in a county that had a vigorous outreach and referral program; a similar county without such a program retained an average of 114 hospital days for similar patients.

Programs of geriatric screening can have great value in finding still-minor disabilities which, if left undiagnosed and untreated, can lead to severe handicap. Such conditions which are very much amenable to early detection and treatment include glaucoma, hypertension, some types of anemia, depression, hearing disorders, diabetes, some cancers, and over-medication.

The objective of an early detection program should be to preserve physical and mental health and enable older people to remain in their homes for as long as they wish and are able to do so. The screening should consist of systematic examination covering total physical, mental and social health.

Health surveillance and health maintenance for the elderly are most effective when a comprehensive, integrated system of geriatric services is provided at a single location.

One reason is that many of the conditions common among the aged are linked with other conditions. Diabetes, for example, may be associated with peripheral blood vessel disease which requires good foot care. But visual impairment, common in elderly diabetics, makes such care difficult and limited mobility due to arthritis may compound the problem.

Special diets may be necessary for people with diabetes, heart disease, or hypertension. Diets of elderly people are more likely to be deficient—in calcium, iron and fiber, for example—than those of the rest of the population. Taste and smell alterations in older people may diminish enjoyment of food, creating difficulties in satisfying nutritional needs. And absence of teeth, problems with dentures, and gum disease can make the situation worse.

Many elderly people, therefore, need a range of services—dietary guidance, eye care, foot care, dental care, and social assistance, as well as routine medical care. And these are best provided at one center.

Social and Psychological Factors of Dependency

Abrupt changes in social dynamics and the elderly often face them—can create severe emotional stress and lead to serious physical illness, even premature death.

Older people are especially likely to experience drastic changes in family circumstances as spouses die and children move to other cities.

The stress of loss and grief is compounded by the absence of support which a family can provide. Stress is exacerbated still more when death of a spouse forces the survivor to change living arrangements and move to unfamiliar surroundings.

The elderly, too, must adjust to the change in status which comes with retirement—including the associated financial constraints many experience.

Although the number of older people living in poverty has dropped by 60 percent since 1959, due in large measure to Social Security benefits, still 14 percent of older Americans have incomes below the poverty level—a proportion higher than for the population as a whole (less than 12 percent).

Moreover, elderly blacks are affected to a much greater extent; 36 percent have below-poverty income levels. And women are constrained—with median incomes only about half those of men ($3,100 annually versus $5,500 for men in 1977).

Fear of the cost of severe illness may cause older people to conserve their limited financial resources. They select cheaper foods and housing, and make more limited use of preventive health services. Too often, the fear—let alone the reality—of financial straits prevents elderly people from leading the full and active lives of which they are capable.

Depression, a significant problem, may reflect loss of purpose in life. It is also related to presence of physical disease, loss of friends and relatives, other social difficulties, economic problems, and sometimes side effects of drugs often used by the elderly for such conditions as Parkinson's disease and hypertension.

Depression can be mentally and emotionally devastating, responsible for suicide or for seeming senility which may lead to needless institutionalization. It can exacerbate existing physical symptoms and may provoke new physical symptoms.

Many kinds of care and services are needed to deal with the complex, interrelated social, mental, and physical aspects of aging.

Limited dependency need not lead inexorably to total dependency. All who are functionally dependent, whether for a physical or mental condition, must be allowed—and encouraged—to do as much as possible for themselves, otherwise their abilities may deteriorate rapidly.

Absence of opportunity to choose among care and service options—as well as to participate in everyday tasks and decisions—is likely to produce apathy and accelerate dependency. The opportunity for choice not only promotes health; it also helps preserve individual dignity and sense of worth.

We know now what programs and services can help prevent deterioration, avoid needless institutionalization, and maintain functional independence.

They include programs for: safe and affordable housing; nutritious food availability through "meals on wheels" and group meal services; communication and transportation services, including telephones and escorts; recreation and education programs to promote enjoyment, challenge and stimulation; community centers to offer social opportunities; in-home services such as homemaker, visiting nurse, and home health care; ready access (including by telephone) to advice from a health professional; provision of eyeglasses, hearing aids, talking books, and large print publications; legal aid and counseling services; volunteer and employment opportunities to provide a continuing sense of purpose in life; and, not least of all, exercise.

Exercise and fitness for older people need emphasis. Aging is not—or should not—be a process of mere passivity. Nor should the obsolescent image of inevitable incapacitation be allowed to continue. Movement is part of functional living—and the quality of intellectual and physical performance is enhanced by remaining or becoming physically fit in old age.

Evidence for the viability of activity in enhancing function in old age is being developed through long-range studies such as those of the Gerontology Center of the University of Southern California. These studies indicate that people in their sixties and seventies and even beyond can retain, with carefully planned exercise, much of the vigor of their forties.

Older people can be more functionally independent.

Subgoal: Reducing Premature Death from Influenza and Pneumonia

In 1977 influenza and pneumonia together constituted the fourth leading cause of death among older people.

It may be true that for some of the elderly who are in late stages of physical and mental deterioration, death from these acute infections may not be untimely. Pneumonia has been called "the old man's friend" for the painless ending of life it may provide.

But many deaths occur in older people otherwise healthy and with much yet to live for. They can be prevented.

The greatest risk from the yearly influenza outbreaks occurs among the chronically ill and elderly.

A person over 75 is more than 10 times as likely to die of influenza as someone aged 55 to 64. Many of the chronically ill also are older persons. Chronic conditions which increase risk include: heart, lung, and kidney disease; diabetes and other metabolic disorders which increase susceptibility to infections; severe anemia; and diseases, including some malignancies, which compromise the body's defensive immune system.

For all high-risk individuals, annual vaccination against influenza is recommended—and those over age 65 should therefore seek the advice of public health authorities and personal physicians.

For pneumococcal pneumonia, we now have a significant development. This lung infection has been responsible for 54,000 deaths a year. Even with antibiotic treatment, it has been a serious threat to older people. The death rate has been 2.5 times higher for those aged 65 to

74, and 10 times higher for those 75 to 84, than for the population as a whole.

A newly-developed pneumococcal vaccine promises to be an effective preventive measure—particularly for special populations of the elderly, such as those in nursing homes and institutions where, because of close contact, disease spread is more rapid.

And prevention of both influenza and pneumococcal pneumonia can be vital for people with chronic lung diseases. Bronchitis, emphysema, and asthma are prevalent among the elderly and together constitute the eighth leading cause of death after age 65. The elderly with such conditions cannot tolerate well the added burden of acute respiratory infections.

Other Important Problems

Of American babies born today, three-fourths can expect to reach age 65; almost half will reach 75; and one-fourth will reach age 85.

Although many people are living longer, there appears to be a biological limit to the lifespan and it seems unlikely that, at least for the near future, any spectacular further gains in life expectancy can be anticipated.

While long life is desired by people in all cultures, quality of life may be even more important. And Americans now are witnessing the emergence of a new concept of aging.

It calls for the highest possible level of health throughout the later years—and, finally, dignified circumstances at the end of life.

It considers that a healthy society will view old age—and the inevitable death at its end—not as unnatural, but an integral part of the life span.

And it calls for society to learn how to help those for whom medical care can offer no more, so that death becomes possible without pain, discomfort, humiliation or financial worries.

A very real concern of the elderly is a prospect of being exposed to sophisticated technology that prolongs life beyond the time when it is meaningful and enjoyable. Nor can they view a busy, impersonal hospital as a comfortable setting for an individual who is dying. They have an additional anxiety: that the high costs of extended hospital stay place a heavy financial burden on surviving spouse or other family members.

Fears and anxieties about conditions surrounding death can be reduced.

When it becomes apparent that death is at hand, the health care system should be willing to accept the obligation to allow it to happen with as little pain and suffering as possible. The patient should be allowed to be in peaceful surroundings, preferably at home. Last year, most older Americans died away from home. When death is near, the greatest comfort lies in being in a home setting amidst the comfort and support that family members can provide.

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Many health problems of the elderly reflect past environments and lifestyles. The occurrence of heart disease, stroke, cancer, and other chronic afflictions may be rooted in earlier life.

When these conditions no longer can be avoided through preventive measures, early diagnosis and treatment very often can postpone death, avoid serious complications, and minimize pain, disability and emotional anguish.

Some health problems may be as much the result of basic human biology as of environment and lifestyle. Arthritis, diabetes, and some types of cancer, for example, may arise from changes in structure and function of aging cells. Even though knowledge is not now available to prevent these diseases, their course can be influenced.

There remain, too, many preventable conditions to which older people are vulnerable—including those such as influenza and pneumococcal pneumonia for which immunizations are available, and those caused or intensified by poor nutrition, lack of exercise, and other lifestyle deficiencies.

Thus, many measures can be applied to increase independence, self-sufficiency and quality of life for the elderly.

CHAPTER 10

HEALTH PROMOTION

Medical care begins with the sick and seeks to keep them alive, make them well, or minimize their disability.

Disease prevention begins with a threat to health—a disease or environmental hazard—and seeks to protect as many people as possible from the harmful consequences of that threat.

Health promotion begins with people who are basically healthy and seeks the development of community and individual measures which can help them to develop lifestyles that can maintain and enhance the state of well-being.

Clearly, the three are complementary, and any effective national health strategy must encompass and give due emphasis to all of them.

Beginning in early childhood and throughout life, each of us makes decisions affecting our health. They are made, for the most part, without regard to, or contact with, the health care system. Yet their cumulative impact has a greater effect on the length and quality of life than all the efforts of medical care combined.

Many factors increasing the risk of premature death can be reduced without medication. In fact, as we have noted, the striking decline in heart disease death rates in this country since the mid-1960s has coincided with reductions in several risk factors: cigarette smoking by men, consumption of high fat products, average serum cholesterol levels, and the number of people with untreated high blood pressure (Figure 10-A). During the same period in Europe, neither personal risk factors nor heart disease death rates declined.

Consider, too, the strikingly lower cancer rates among certain groups of Americans compared to those for the general population.

Seventh Day Adventists neither smoke nor drink, and about half follow a milk, egg and vegetable diet. For this group, not only is their cancer incidence, for those cancers strongly related to smoking and drinking, less than one seventh that of the general population; even their cancer incidence at other sites is only half to three-fourths as high. Similarly, Mormons, who also abstain from smoking and alcohol, have lower cancer rates.

And there are the promising results coming from recent efforts to organize community resources for health promotion.

Notable examples include the Stanford Heart Disease Prevention Program and the Multiple Risk Factor Intervention Trial (MRFIT), both funded by the National Heart, Lung, and Blood Institute.

The Stanford program, begun in 1972, has been monitoring the rates of cigarette smoking, serum cholesterol levels, and uncontrolled hyper-

FIGURE 10-A

PERCENT DECREASES IN RISK FACTORS FOR CORONARY HEART DISEASE*

Risk Factor	Approximate Percent Decrease	Time Period
Cigarette smoking (% who smoke):		
Men	26	1964-1975
Women	8	
Per capita consumption of:		
Tobacco	22	1963-1975
Fluid milk and cream	20	
Butter	32	
Eggs	13	
Percent with high cholesterol (260 mg/100 ml plus):		
Men age 45-54	6	c1962-c1975
Men age 55-64	14	
Women age 45-54	13	
Women age 55-64	29	
Percent hypertensives untreated:		
In U.S.	10	c1962-c1974
In 14 U.S. cities†	25	

*Note: Coronary heart disease deaths (to which these risk factors are related) declined by 20 percent in the period 1968-1976.

†Part of a special National Heart, Lung, and Blood Institute study program.

tension in three Northern California communities. Two of the three employed active risk reduction activities, including messages designed for television, radio, newspapers and other media. In one of these two communities, face-to-face counseling also was provided for a sample of high risk individuals.

Within a two-year period in the two experimental communities, overall heart disease risk fell by about 25 percent. In both, there were reductions in average serum cholesterol and a six percent lowering of systolic blood pressures. A substantial reduction (net decrease of 35 percent) in smoking was achieved only among the high-risk individuals receiving counseling. In the community without an active information program, overall risk for heart disease actually increased during the first two years of the study.

The Multiple Risk Factor Intervention Trial program also seeks to change behaviors with respect to smoking, serum cholesterol, and high blood pressure. It is a multicenter clinical trial in 22 communities to determine whether, for men at high risk, a concentrated program based on counseling and directed simultaneously toward the three risks will result in a significant reduction in heart disease deaths.

Although final study results will not be available until 1983, preliminary data are especially encouraging with respect to the numbers of participants who have stopped smoking and those whose high blood pressure is under control. Moderate cholesterol reduction also has been achieved.

Abroad, promising results have come from a program in the province of North Karelia, Finland, which has the highest documented heart disease rate in the world.

In the early 70s, more than half of the men in North Karelia smoked; they also had extremely elevated cholesterol levels and high consumption of animal fats and dairy products; untreated hypertension was common.

Concerned about their high heart disease rate, North Karelians developed a massive health promotion campaign designed to help the 180,000 province residents control their blood pressure, reduce cholesterol intake, and stop smoking. Efforts included promotion of low-fat dairy products and low-fat sausages by local industries, training of local residents as health personnel, and extensive media coverage.

After five years there was an 18 percent drop in cigarette smoking among men ages 25 to 60 and a 15 percent decline among women. Butter consumption dropped and 50 percent of the population was using low-fat milk. The number of men with high blood pressure declined by 27 percent. Among women, the decline was 49 percent.

And significantly, preliminary results yet to be confirmed show a drop of 17 percent in heart attack incidence and 33 percent drop in the incidence of stroke among North Karelian men.

Here at home too, after the University of Southern California Medical Center ravamped its diabetic care system—by installing a telephone hotline for information and advice, making available counseling by physicians and nurses, and issuing pamphlets and posters to promote the service— emergency room visits per patient were halved and the incidence of diabetic coma decreased by two-thirds.

Relatively simple community health education programs, now increasing in number, can indeed make contributions.

This chapter deals with five types of behaviors which affect health and are targets for health promotion programs: smoking, alcohol and drug use, nutrition, exercise and fitness, and management of stress.

Smoking Cessation

Cigarette smoking is clearly the largest single preventable cause of illness and premature death in the United States.

It is associated, as Section II noted, with heart and blood vessel diseases; chronic bronchitis and emphysema; cancers of lung, larynx, pharynx, oral cavity, esophagus, pancreas, and urinary bladder; and with other ailments ranging from minor respiratory infections to stomach ulcers. Smoking during pregnancy also increases risks of complications of pregnancy and retardation of fetal growth.

Cigarette smokers have a 70 percent greater rate of death from all causes than nonsmokers, and tobacco is associated with an estimated

320,000 premature deaths a year. Another 10 million Americans currently suffer from debilitating chronic diseases caused by smoking.

A remarkable aspect of these statistics is that smoking presumably is voluntary, and theoretically all of this damage is therefore preventable.

Moreover, a large portion of a smoker's excess risk for heart disease disappears within two years after quitting—and within 10 to 15 years an exsmoker's chance of early death from a heart attack is no greater than that of someone who never smoked. If, in fact, all Americans stopped smoking, coronary deaths could be reduced by approximately 30 percent, with a saving of more than 200,000 lives a year. And people who have smoked for many years can reduce their risk of lung and urinary bladder cancer if they stop.

Changing Trends

In 1950, when the Nation first became generally aware of an association between smoking and lung cancer, there were about 18,000 lung cancer deaths. In 1964, the year of the first Surgeon General's Report on Smoking and Health, there were over 45,000 lung cancer deaths. An estimated 92,000 deaths from lung and related respiratory system cancers occurred in 1977.

The 1964 Surgeon General's Advisory Committee Report concluded that cigarette smoking was a cause of lung cancer in men and was associated with coronary artery disease, chronic bronchitis, and emphysema. Since then, cigarette smoking's relationship to these diseases—and to still others—has become clearer. A comprehensive review of the evidence linking smoking with a wide variety of health problems—with particular attention to special smoking-related problems for women, children and workers—is presented in the 1979 Surgeon General's Report on Smoking and Health.

The public's reaction to the risks of smoking can be measured by changes in cigarette consumption. In the early 1950s, consumption declined in response to the first scientific reports. It rose again, then dropped when the Surgeon General's Report was published in 1964, then rose a second time but dropped again between 1968 and 1970 as more television advertisements against smoking were aired.

All in all, more than 30 million smokers have quit since the first Surgeon General's Report, and the proportion of adult smokers has declined from about 42 percent in 1965 to a little more than one-third today. A large share of the decline is due to a drop in the proportion of men who smoke, but the percentage of women who smoke has decreased negligibly and there has been a doubling of the rate at which adolescent women (12 to 18 years) smoke.

Though the recent decline in the proportion of men who smoke is encouraging, an associated decline in cancer death rates may not appear for some years because cancer takes many years to develop. But the fall-off of heart disease deaths is undoubtedly due in part to the shift.

On the other hand, if the proportion of women who smoke does not decrease and current trends continue, experts predict that lung cancer will surpass breast cancer as the leading cause of cancer mortality among women by 1983.

Meanwhile, approximately 4,000 children and adolescents become cigarette smokers each day. While girls in the 1960s were smoking at about half the rate of boys, they now smoke as much. More than 20 percent of 12 to 17 year olds and about one-third of all 18 year olds now are regular smokers.

Approaches to the Problem

Much more can and must be done to educate the public about the risks of smoking.

Although Americans know about the relation between smoking and lung cancer, surveys show that they have yet to become aware that smoking-related cardiovascular diseases claim even more lives. And few believe they personally will suffer any harmful effects.

Physicians and dentists could be more helpful. Surveys show that only two-thirds of doctors and one-third of dentists routinely inquire about their patients' smoking habits. Only 25 percent of smokers say their physicians have told them to quit. Most physicians and dentists apparently wait until a serious smoking-related symptom or ailment has appeared, yet studies show that if doctors advise patients not to smoke, as many as 25 percent will quit or reduce the amount they smoke.

Most people say they intended to smoke for only a short time and well over half of new smokers confidently expect to stop within five years. The reality, however, is that once started the smoking habit is extremely difficult to overcome. About 90 percent of all current smokers have expressed a desire to quit.

To help smokers quit, many clinics, techniques, and devices have been developed over the past 20 years and different methods have succeeded to some extent with different individuals. But reverting back to smoking is a major problem for many people and effective techniques are needed to help exsmokers avoid tobacco.

Actually, 95 percent of smokers who successfully quit do so on their own. And four factors seem to be of major importance in their success: health concerns (including symptoms); a desire to set an example for others; a desire for self-control; and aesthetic reasons such as breath odor and loss of taste for food.

These motivations should therefore be stressed in anti-smoking literature, advertisements, and broadcast announcements, as well as in special information campaigns directed to such high risk groups as pregnant women, industrial workers in especially hazardous occupational settings, and persons with health problems likely to be worsened by smoking.

Special efforts should be directed to children and adolescents. School health education curricula are needed to help a child make intelligent decisions about smoking—as well as about other behavior affecting health—and to help reinforce those decisions against peer pressure and other forces that impel them toward serious risk-taking behavior.

Effective curricula already in existence need to be more widely used. Educational activities must begin at the earliest possible point in school and continue systematically throughout the child's educational experience.

The best of these programs emphasize not only knowledge of the human body but also how it works and how behavior affects it. They also impart attitudes of personal responsibility for protecting one's own health and means of coping with pressures and uncertainties.

Efforts for teenagers must be designed to help them deal with their own values and attitudes toward smoking and with their own sense of maturity. They should be aimed at helping them develop the ability to resist group pressures toward smoking and at reinforcing the concept that, in fact, smokers are the minority—not majority—both in their own age group and among adults.

One approach, which makes positive use of the peer pressures that influence youthful behavior, is deploying students themselves as health educators. Such peer instruction programs have shown substantial promise in preliminary trials.

Some have suggested use of economic sanctions such as increased taxes to discourage smoking. This is a complex political and economic issue not readily accomplished. But the effect of price changes—particularly of dramatic changes—on consumption merits further investigation.

Development of lower tar cigarettes has been urged as a means of reducing hazards. And smokers can take a first step toward quitting and hazard reduction by using low tar and nicotine cigarettes. They can also reduce hazards by not smoking to the end of a cigarette, by taking fewer puffs on each cigarette, by reducing inhalation and, gradually, the number smoked daily.

While gradual reduction is better than no reduction at all, it should be noted that generally smokers who quit all at once have better success than those who try to quit in steps.

Also, there is no known safe cigarette—including the low tar and nicotine varieties—nor any safe level of smoking for any type of cigarette. The smoker who continues to smoke, even in reduced amounts, still runs a significantly greater risk of illness and death than the nonsmoker.

Finally, the rights of nonsmokers should be recognized and supported. Measurable levels of nicotine have been found in the blood and urine of nonsmokers exposed to tobacco smoke. Such exposure may present a special health hazard for people with certain diseases. Breathing the smoke of others can lead to unsafe carbon monoxide levels, allergic reactions, and exacerbation of conditions such as asthma and bronchitis. For infants, risk of respiratory infections increases when parents smoke.

Legislation has been introduced in every state to restrict smoking in public places. Steps are being taken to restrict smoking in government buildings and facilities as well as on buses, airplanes, and passenger trains.

Despite all the difficulties, efforts to increase the number of nonsmokers should become much more energetic. The World Health Organization notes in a recent report: "The control of cigarette smoking could do more to improve health and prolong life in (developed) countries than any other single action in the whole field of preventive medicine."

Reducing Misuse of Alcohol and Drugs

Alcohol and other psychoactive substances exact a substantial toll of premature death, illness, and disability in the United States.

Alcohol

Because of its overuse and general social acceptance throughout American society, alcohol accounts for a significant share of the Nation's medical care cost burden.

Alcohol misuse is a factor in more than 10 percent of all deaths in the United States—about 200,000 a year. It is associated with half of all traffic deaths, many involving teenagers. Cirrhosis, which ranks among the 10 leading causes of death, is largely attributable to alcohol consumption. Alcohol use is also associated with cancer, particularly of the liver, esophagus and mouth. Primary liver cancer is almost exclusively attributed to alcohol consumption. People who drink and also smoke cigarettes have even greater increases in esophageal cancer rates. And excessive drinking during pregnancy can produce infants with severe abnormalities, including mental retardation.

Nor is the death and injury toll only for alcoholics or problem drinkers. Accidents, in particular, often involve the occasional drinker who is temporarily out of control.

Per capita consumption of alcohol by Americans increased during the 1960s—a trend generally attributed to the lowering of the legal drinking age in many States, an increase among young people consuming alcohol, and increasing use of alcohol by women.

The proportion of heavy drinkers in the population grew substantially in the 1960s to reach the highest recorded level since 1850, though it has leveled off in recent years. Drinking is greatest in the younger years and declines after age 50.

Currently, average consumption of alcohol for all persons older than 14 is 30 percent higher than 15 years ago—about 2.6 gallons of ethanol annually, representing a total of 28 gallons of beer, plus 2.5 gallons of distilled spirits and 2.25 gallons of wine.

Ten million adult Americans—seven percent of those 18 years or older—are estimated to be alcoholics or problem drinkers.

Of all adults who drink, more than a third have been classified as either current or potential problem drinkers, with women making up one-fourth to one-third of the latter. Youthful problem drinkers, aged 14 to 17 (intoxicated at least once a month) are estimated to number more than three million, between 20 and 25 percent of the age group.

The social and economic burdens associated with alcohol are enormous. Those who abuse drinking affect not only themselves but their 40 million family members as well. Alcohol abuse and alcoholism are estimated by the Alcohol, Drug Abuse and Mental Health Administration to have cost the Nation nearly $43 billion in 1975, including health and medical costs, lost production, motor vehicle accidents, violent crimes, fire losses, and social response programs.

Drugs

Although there is no question that drug misuse is a major problem, reliable information on actual prevalence is hard to obtain. Much depends on self-reporting and many problems occur among transient populations likely to be missed in any survey.

Moreover, interpretation of surveys is complicated by lack of agreement on what frequency of use of drugs constitutes abuse.

Heroin addiction, the most serious drug problem in the United States, appears to be declining. In 1978, there were an estimated 450,000 addicts, compared with an estimated 550,000 in 1975. It should be noted that the decline parallels demographic changes in the number of young adults.

The toll from highly addicting heroin includes premature death and severe disability, family disruption, and crime committed to maintain the habit. The heroin user is at very high risk of overdose death, of hepatitis and other infections from contaminated equipment and impurities in the drug, and from chronic undernutrition because money is spent on heroin instead of food. Preventing consequences of overdose and infection in users is virtually impossible since there is no control over the strength and purity of the drug or the means of administration.

Central nervous system depressants and stimulants with potential for abuse include many drugs ordinarily prescribed for their medical value. At least one million Americans are believed to misuse barbiturates or other sedative-hypnotic drugs and 30,000 are estimated to be addicted to them.

Excessive doses of depressants over a long period can result in both physical and psychological dependence, with abrupt withdrawal (particularly of barbiturates) leading to convulsions which may produce permanent disability or even death. Overdosing with barbiturates—intentional and accidential—is a leading cause of drug overdose fatalities but has declined somewhat as physicians have changed prescribing practices. Combinations of barbiturates with depressants, particularly alcohol, greatly increase the chance of death.

Cocaine is a stimulant which—despite its high cost—has become very popular for its propensity to induce euphoria and reduce feelings of fatigue. Some 10 million Americans have tried cocaine at least once and one to two million are current users. Although physical dependence does not develop, psychological dependence may. Some deaths due to toxic reactions to cocaine have been reported.

Hallucinogens, which distort perception of reality, can cause potentially fatal toxic reactions. And their unpredictable psychic effects may result in unintentionally dangerous behavior. One hallucinogen, PCP (phencyclidine hydrochloride), has a well-deserved street reputation as a "bad" drug, yet many people use it regularly, and in 1977 it was associated with at least 100 deaths and more than 4,000 emergency room visits.

Other illicit drugs—with less harmful physical and social consequences—are in more widespread use.

There are some 16 million current marijuana users. Among males 20 to 24 who have ever used marijuana, perhaps 17 percent are daily

users. Among high school seniors recently surveyed, about 10 percent reported daily use. Of special concern is the relationship of marijuana to automobile accidents; especially when used in combination with alcohol, and by teenagers and young adults who are at high risk of accidents.

One of the dominant concerns about use of marijuana and other psychoactive drugs is the reduction in motivation and performance they may produce when used chronically, particularly by children and adolescents.

Prevention Programs

Helping people to stop or avoid starting misuse of alcohol or drugs will not be easy—particularly among population groups in which social and economic factors are prominent contributors to abuse of alcohol and drugs, and therefore complicate potential interventions.

For the broad range of alcohol and drug problems, strategies for intervention differ; but there are some common elements. They include: prevention through education that starts early and extends throughout life; altering the social climate of acceptability; reducing individual and social stress factors; and law enforcement.

One reason recent alcohol education efforts have had little success in changing children's behavior is that their moralistic nature has not always matched parental behavior or the favorable image afforded alcohol use in television advertising and programming. Such dichotomy creates confusion in young minds.

Similarly, efforts to educate young people about drug abuse dangers have met with skepticism—and, in fact, on occasion, the excitement and drama employed to discourage a drug's use have created an incentive to try the drug.

Educational strategies directed against drugs themselves appear to be less effective than those built around the concept of individual responsibility for the daily decisions that can affect health.

Young people who gain an understanding of how body systems work and how their personal choices affect their well-being are better prepared to make wise choices about alcohol and drug use. For this reason, comprehensive school health education programs directed toward strengthening children's decision-making capabilities may hold particular promise.

Moreover, because peer pressure, as noted earlier, has profound influence on youth behavior, educational programs that build on peer group counseling are more likely to be successful. School systems, youth-related organizations such as the Boys Club of America, Catholic Youth Organizations, 4-H and the Scouts, and churches and other community-based organizations can help develop such programs.

These programs serve many purposes. They open communication channels between adolescents and the health community; they teach young people tangible skills and give them important information, thus increasing their sense of self-worth; they also provide needed community services.

Our society needs to find more socially constructive outlets for the interests and energies of children and adolescents. While urbanization and farm mechanization have moved rapidly, alternative activities for the work once required have not been adequately developed. Challenging work for young people is important for more than economic reasons; it helps build self-respect and a better outlook for the future.

The media can be important in creating a social climate that encourages sound health-related personal decisions. In recent years, television has reduced its emphasis on the social acceptability of smoking—only, ironically, to have lighting a cigarette replaced in part by pouring a drink as a typical stage routine.

Labeling policies for alcohol and prescription drugs may provide an important means for conveying information which will help users to avoid harmful affects. Product labels may be especially useful for informing expectant mothers of the potential effects of ingested substances on the fetus.

Help and support must be offered to those already suffering from misuse problems. For alcohol-related problems, Alcoholics Anonymous, similar organizations for families of alcoholics, and workplace-based programs may be successful.

Health professionals need to play a more active role. A physician who diagnoses cirrhosis has no difficulty in recommending against alcohol use but may miss earlier opportunities to make the recommendation when the advice could make a difference.

Physicians and pharmacists can also be very important in reducing availability of legal drugs which may be abused. Physicians need to exercise more caution when prescribing psychoactive drugs, and pharmacists should check with physicians when in doubt about prescriptions.

Finally, legislation and law enforcement can help. The experience of some jurisdictions indicates that social practices may be substantially modified through vigorous enforcement of laws such as those against driving while intoxicated, and careful study of the efficacy of such measures is warranted.

Improved Nutrition

Although evidence keeps mounting that certain food factors and current dietary habits may be linked with health problems as diverse as heart disease, tooth decay, obesity and some types of cancer, consumers often find it difficult to make informed choices about food.

Most know that good nutrition can make a substantial contribution to health and development of infants and children and that healthy eating patterns should be firmly established in adolescents and young adults. Most also are aware that good nutrition is particularly important for pregnant women and the elderly.

But food choices are influenced by many complex factors and the consumer is often bombarded with an overload of somewhat confusing—and even conflicting—information from books, newspapers, magazine articles, and advertising.

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Most diet deficiency diseases prevalent early in the century are now rarely seen. But iron deficiency in children and women of childbearing age remains a public health concern.

And although less than one percent of the American people can be considered undernourished in the traditional sense, data from the first Health and Nutrition Examination Survey by the National Center for Health Statistics show a trend toward low calorie intake among certain adults over age 45, and particularly among women over 60. If the trend continues, it is possible that some diet deficiency diseases may reappear.

Nevertheless, today's nutrition problems are still more likely to be associated with eating too much and with imbalance in the kinds of foods eaten than from eating too little.

The Obesity Problem

Thirty-five percent of women between ages 45 and 64 with incomes below poverty level and 29 percent of those with incomes above are considered obese, according to the National Center for Health Statistics. The comparable figures for men are five and 13 percent.

Obesity is clearly related to diabetes, gallbladder disease, and high blood pressure. In association with other risk factors, it can contribute significantly to heart disease. In addition to the physiological problems, obesity may have serious social consequences for the young person growing up in a society which prizes slimness and athletic ability.

A genetic component may be involved in some obesity. But the social environment of the family— eating and exercise habits and a tendency to view food as a "reward"—is of great importance. And, as noted in Chapter 4, obese children are three times more likely to be obese adults than children who are not overweight.

There is no quick, easy solution to obesity. Among adults, it has proved very difficult to reverse on a lasting basis.

Permanent weight loss has been found somewhat easier to achieve by people who inventory their food intake, avoid situations that would entice them to overeat, and gradually change their eating and exercise habits. Many nutritionally sound diets are available for weight control, but people should be extremely skeptical about fad diets promising rapid, painless weight reduction.

Obesity is not the only nutrition-related health problem. Cardiovascular disease and cancer are other public health concerns that may be diet-related.

Nutrition and Cardiovascular Disease

A good case can be made for the role of high intake of cholesterol and saturated fat, usually of animal origin, in producing high blood cholesterol levels which are associated with atherosclerosis and cardiovascular diseases.

Animal studies have shown that reducing serum cholesterol can slow down and even reverse the atherosclerotic disease process.

And, in man, certain studies have shown that people in countries where diets are low in saturated fats and cholesterol have lower aver-

age serum cholesterol levels and fewer heart attacks; and that Americans who habitually eat less fat-rich diets (vegetarians and Seventh-Day Adventists, for example) have less heart disease than other Americans. Other observations in man suggest the possibility that certain types of atherosclerosis may be reversed by cholesterol-lowering diets.

The weight of the evidence, therefore, now suggests that Americans who have been consuming high fat diets should attempt to reduce serum cholesterol by changing eating patterns. Moreover, these changes should begin at an early age. Not only adults but children in countries with low coronary heart disease rates have much lower serum cholesterol levels than many of our children have.

Many issues still need to be resolved. Among the most interesting are those concerned with high and low density lipoproteins (see Chapter 6). While it appears that a higher ratio of high-density to low-density lipoproteins carries a lower risk for heart disease, the effect of diet upon the ratio still is under study.

Some investigations indicate that the ratio is favorably influenced by lean body weight, regular vigorous exercise, smoking avoidance, consumption of small amounts of alcohol, and a diet with relatively more vegetables, fish and white meats than red meats. But further research is needed before definite statements can be made about diet and lipoproteins.

High dietary salt intake may produce high blood pressure, particularly in susceptible people. Unequivocally, studies in genetically predisposed animals show a cause-effect relationship between high salt intake and elevated blood pressure. Studies in man also suggest such a relationship and show, too, that when hypertension is present controlling salt intake can help combat it.

A prudent approach, given present knowledge, would be to limit salt consumption by cooking with only small amounts, refraining from adding salt to food at the table, and avoiding salty prepared foods. Careful label reading will reveal whether salt or a sodium compound has been added to a packaged food.

Diet and Cancer

The association between diet and cancer is more tenuous than between diet and heart disease.

Because populations with different dietary patterns have differing cancer rates—and emigrants assuming the patterns of their adopted country soon also assume new cancer rates—there has been much research into the possible diet-cancer association.

Studies in human populations have suggested a number of possibilities: that high consumption of animal protein may be linked to colon cancer; that low consumption of fiber from plant sources may also be linked to colon cancer; and that high consumption of fats, both saturated and unsaturated, may be linked to colon cancer and to hormone-related cancers of the ovary and prostate. All of these possibilities need further investigation.

Healthy Nutrition

Individual nutritional requirement variations make exact dietary standards impossible to establish. Variations also occur in the same person at different times—during pregnancy, with aging, during acute or chronic illness, or with changes in physical activity.

But given what is already known or strongly suspected about the relationship between diet and disease, Americans would probably be healthier, as a whole, if they consumed:

- only sufficient calories to meet body needs and maintain desirable weight (fewer calories if overweight);
- less saturated fat and cholesterol;
- less salt;
- less sugar;
- relatively more complex carbohydrates such as whole grains, cereals, fruits and vegetables; and
- relatively more fish, poultry, legumes (e.g., beans, peas, peanuts), and less red meat.

Adequate, balanced nutrition can be obtained by eating—in quantities sufficient to maintain desirable weight—a wide variety of foods each day, including meat or meat alternates, fruits and vegetables, cereal and bread-type products, and dairy products.

The processing of our food also makes a difference. The American food supply has changed so that more than half of our diet now consists of processed foods rather than fresh agricultural produce. Because of this change, we need more complete nutrient composition data about our food supply, particularly as related to some of the newer essential "trace minerals" such as molybdenum, manganese, chromium, and selenium.

The quantities of these trace minerals have not previously been a nutritional concern because practically everybody consumed a variety of fresh or minimally processed foods. Increased attention therefore also needs to be paid to the nutritional qualities of processed food.

Better Nutrition Education

Food choices are determined in part by the nutritional knowledge of the person who buys or prepares the food. Other factors include availability, personal and family likes and dislikes, and marketing and advertising practices. These factors should be addressed in educational initiatives to promote good food habits.

Until now, nutrition education has provided information rather than instruction in the skills that can be used to improve dietary habits.

Such skills should be taught in formal and informal nutrition education programs for people of all ages. And these programs should consider what too often has also been neglected in the past: the differences in food preferences found in different cultural groups.

Teachers, in particular, need to receive training in nutrition; and nutrition should be an integral part of the school curriculum.

More can also be done in medical care settings. Although education about nutritional intake is essential and often provided for patients suf-

fering with health problems such as diabetes or kidney disease, it is uneven in quality.

And although pediatricians, obstetricians and other health workers often include some form of nutrition education as part of their care of infants, mothers, and pregnant women, rarely do they take advantage of this opportunity to build nutritional knowledge and positive attitudes for future decision-making.

Training in nutrition for physicians and other health professionals should have high priority, and nutrition training and services should be promoted in hospitals and clinics.

Sound nutrition information should also involve the media. Food advertising, particularly on television, has a powerful influence on food choices. Many foods are promoted for their convenience and ease of preparation or for their taste, rather than for nutritional value. Convenience and good taste are important considerations, but a balanced presentation should also consider nutritional value.

Results in the Stanford Heart Disease Prevention Program suggest that structured campaigns using multiple media sources can positively affect food selections to reduce, for example, consumption of products high in cholesterol or salt.

Education efforts must be augmented by direct food assistance to segments of the population finding it difficult to meet basic nutritional needs.

Certain older adults—for example, those with chronic diseases, acute illnesses, or particular genetic or lifestyle patterns—absorb nutrients less efficiently. But the primary problem for many of the elderly and other age groups is poverty and fixed incomes.

A number of Federal food distribution and supplemental food programs have been established to provide poor people with better diets. Among them are the nutrition services programs (including congregate and home-delivered meals), the Food Stamp Program, and the Special Supplemental Food Program for Women, Infants, and Children administered by the Department of Agriculture. Measures are needed to strengthen these programs and to assist people in using them.

Exercise and Fitness

For more than a generation, American living has become increasingly sedentary. Most of us drive or ride to work and most other places. Work itself, for much of the labor force, involves relatively little, if any, vigorous physical activity. Even in recreation, people commonly have tended to be spectators, not participants. The relative lack of physical activity has led to a decline in physical fitness among youth and adults alike.

Within the past half dozen years or so, however, there has been a promising resurgence of interest in physical exercise and fitness. A 1977 Gallup Poll found nearly half of American adults saying that they exercise regularly to keep fit. Millions participate in tennis, bicycling, swimming, calisthenics and other forms of exercise. Running, in particular, has become a very popular pastime even though it is in reality confined to a relatively small, and highly visible, portion of the population. (Ac-

cording to the National Center for Health Statistics, five percent of Americans over age 20, and 10 percent of men aged 20 to 44 run.)

Health Effects

Physical fitness activities affect health in many ways.

People who exercise regularly report that they feel better, have more energy, often require less sleep. Regular exercisers often lose excess weight as well as improve muscular strength and flexibility. Many also experience psychological benefits including enhanced self-esteem, greater self-reliance, decreased anxiety, and relief from mild depression.

Moreover, many adopt a more healthy lifestyle—abandoning smoking, excessive drinking, and poor nutritional habits.

Sustained exercise improves the efficiency of the heart and increases the amount of oxygen the body can process in a given period of time. Compared to non-exercisers, people who engage in regular physical activity have been observed to have one and a half to two times lower risk of developing cardiovascular disease, and an even lower risk of sudden death.

While not yet definitively proven, the role of exercise in preventing heart disease is attractive and plausible. An example of the growing evidence supporting the association between exercise and reduced cardiovascular risk comes from a study of 17,000 Harvard alumni. The physically active among them had significantly fewer heart attacks than the more sedentary. Those who expended less than 500 calories a week in exercise developed heart disease at about twice the rate of those expending 2,000 or more calories a week (approximately 100 calories are used for each mile run or walked). Regular, vigorous exercise was found to reduce risk of heart disease independently of other risk factors such as cigarette smoking or high blood pressure.

The kind of physical activity probably most beneficial to the cardiovascular system is sometimes called aerobic—exercise requiring large amounts of oxygen for energy production. Examples include brisk walking, climbing stairs, running, crosscountry skiing, and swimming.

An average of 15 minutes or more of aerobic exercise is thought to produce beneficial effects which are further increased when the exercise is done vigorously.

A reasonable goal for any individual ought to be 15 to 30 minutes of exercise at least three times a week. A beginner should start slowly and people over 40 should be examined by a physician first.

Non-aerobic activities, such as weight training and calisthenics, are useful for enhancing muscle tone, strength and flexibility. But they are often intermittent and less vigorous, and therefore may be less effective in reducing risk for cardiovascular disease.

The risk may be reduced by regular, sustained exercise in several ways. Such activity may cause the blood pressure of a hypertensive individual to fall an average of 10 points and may also lower serum cholesterol while raising the level of desirable high-density lipoproteins. It can also get rid of excess weight. Walking or running a mile daily—or swimming one-quarter mile—can lead to a reduction of more than 10 pounds in a year.

Aerobic exercise, when carefully prescribed, has been found useful for patients with chest pain (angina pectoris) and those recovering from heart attacks, enabling them to increase the amount of activity they can perform free of chest pain.

Such exercise has also been shown to be useful in treatment of other diseases. Asthmatics and people with chronic obstructive lung disease often can improve their respiratory capacity. Diabetics can lower their blood sugar levels and insulin requirements, and overweight adults who have become diabetic often are freed of any indications of the disease when they achieve normal weight through exercise and diet.

Gaps and Needs

Despite a doubling of the percentage of those who exercise, most participants do not exercise often or vigorously enough to achieve maximum health benefits.

Participation rates are higher among whites than minorities; among males than females; among younger than older persons; among the more educated than the less educated; among professionals than blue-collar workers; among the affluent than the poor; and among suburbanites than city dwellers.

For children and adolescents, too often exercise involves an emphasis on team sports in which much of the time a player is inactive, and which are rarely engaged in later in life. More valuable would be properly conducted physical education programs that could help promote lifetime habits of vigorous exercise as well as contribute to child growth and development.

Most older people do not exercise regularly. Yet suitable exercise programs can help them in many ways: by reversing the replacement of muscle by fat associated with inactivity; maintaining a good posture and muscular strength required for efficient movement in daily activities; improving joint mobility for the better balance skills needed for safety; and stimulating cardiorespiratory endurance.

Some people who exercise began on their own or because they were influenced by a friend. Other motivating influences include school, employee health fitness programs, health professionals, media, and government programs.

In the early 1960s, responding to the emphasis by President John F. Kennedy through his Council on Youth Fitness, many schools undertook more extensive fitness programs and a number of States began to require daily physical education for school children.

But since the late 1960s, many school physical education programs have had to cut back for lack of adequate State and local funding. Many States today have only limited requirements for physical education and no requirements at all for some grade levels. It has become even more important for parents to see that their children are exercising adequately.

During the past few years, an increasing number of employee fitness programs have been developed in business and government. Some companies have full-time fitness directors in charge of programs. In the most successful activities, participation rates range up to 40 percent,

with benefits accruing to management as well as to workers who, feeling better, often may work better.

Health professionals have largely ignored active promotion of suitable exercise for their patients. A recent survey found 80 percent of patients not remembering that their physicians had ever recommended exercise. When exercise was recommended, it was usually of nonvigorous nature with limited value. More interest and concern by health professionals could do much to get more people exercising.

On a national level, government involvement has largely been through the President's Council on Physical Fitness and Sports. Since 1956, the Council has provided impressive leadership in drawing attention to the importance of exercise and fitness. It has assisted in development of employee health programs, public information programs, and special projects designed to increase participation in fitness and sports activities.

But what is needed is a substantial national effort involving all levels of both public and private sectors.

Stress Control

Stress is normal, inevitable; a part of life. It is experienced in family relationships, school, work, traffic, shopping, financial and other problems. And everyone develops means of coping—more or less effectively.

Some means of coping are beneficial—as, for example, when the response is an effort to improve performance.

But there are destructive responses such as excessive alcohol use, resorting to drugs, violence, reckless behavior, depression, and other forms of mental illness.

There are indications that stress can be related to cardiovascular disease and deaths, gastrointestinal disorders, and other diseases and physical health problems as well as much mental illness.

Studies have indicated that stress in the home, for example, can increase a child's risk of streptococcal throat infection—and an expectant mother's risk of pregnancy complications.

One revealing study assessed pregnant women, married, of similar age, race, and social status, all of whose babies were delivered in the same hospital. The finding: those women undergoing a great deal of social stress and lacking strong social supports—measured by closeness of ties with husband, family, and community—had almost three times the frequency of complications of pregnancy or delivery.

People under stress experience measurable changes in body functions: a rise in blood pressure and secretion of adrenaline and other hormones at higher levels. The changes are basically defensive, mobilizing body energies to meet a threat.

But when stress—or an individual's reaction to it—is excessive, physiologic changes can be so dramatic as to have serious physical and emotional consequences.

Reducing the Harmful Consequences of Stress

Two strategies are needed to minimize destructive stress consequences: preventing or reducing stress itself and improving individual stress-coping skills.

Opportunities for stress prevention exist in the work setting. Many jobs are dull, boring, or dangerous. Many people work under unpleasant circumstances—noise, polluted air, cramped quarters. The fear of losing one's job is an important source of stress.

Many of these factors, as noted earlier, can be eliminated or reduced. The work environment can be improved. Job assignments can be better tailored to individual interests and capabilities. Such improvements may pay dividends in increased productivity and decreased absenteeism and job turnover rates as well as reduced stress for the individual workers.

In the community setting, stress for individuals and groups often can be reduced through helping networks, neighborhoods, and community organizations.

The recent report of the President's Commission on Mental Health noted the significance of support systems in fostering a sense of security and as an effective treatment measure for people suffering problems associated with both physical and mental health.

There is extensive evidence of the importance of a sense of neighborhood or belonging for people and of the meaningful roles in people's lives played by neighborhood institutions such as churches, schools, ethnic clubs, fraternal organizations, community organizations, and others.

In a pluralistic society, people meet needs and solve problems in varied ways. And a neighborhood-based approach—with community support systems designed to address diverse individual needs—can be critical to individual well-being.

Strengthening neighborhood networks can help people in many ways: to gain a sense of control over their lives; reduce alienation from society; improve capacity to solve new problems; and maintain the motivation to overcome handicaps or the frustrations common in modern society.

With adequate day care programs, for example, stressful pressures on working mothers can be reduced. The stressful consequences of unwanted teenage pregnancy and motherhood can be substantially reduced by programs that enable the young women to complete their educations and qualify for satisfactory employment.

Racial and ethnic tensions can be eased through community action to improve cooperation and understanding. Young people at highest risk of becoming school dropouts can be identified and programs can be designed to anticipate and help meet their needs. Elderly people in need of support after retirement or loss of a spouse can be identified and helped through community services.

Efforts to improve coping skills must begin with an understanding of the events most difficult to handle emotionally.

Extensive research in this area has generally confirmed folk wisdom. The death of a spouse, the serious illness of a child, the loss of a job, family disruption and divorce, and other catastrophic changes over

which the individual has little or no control, are the stresses most likely to cause psychosomatic disorders or other emotional problems, and their consequences.

Since stressful events are not always preventable, preparation for dealing with them needs to begin early. Emphasis should be given to building coping skills in children and young people. Too often, stress has been addressed only after the problem is fully developed—by treatment of the alcoholic, the drug abuser, the acutely depressed person, and by penalties for criminal offenders. Much more attention should be given to preparing people to deal in less destructive ways with unavoidable stresses.

To help young people and adults deal with critical stresses as they arise, a number of self-help and mutual support activities have been developed in communities across the country. Many evolved from the crisis intervention centers of the late 1960s. They deal with a wide range of stress-generated or stress-related problems: alcoholism, pregnancy, divorce, suicide attempts, rape, terminal illness, death of a child, death of a spouse, and many others.

There are in addition self-help, mutual aid groups for the handicapped; drug abusers; parents of handicapped children; parents who abuse their children; young people in search of jobs and identity; widows; old people; patients who have heart attacks, colostomies or mastectomies; gamblers; smokers; drinkers; overeaters; and many more. These groups constitute a significant community resource.

Although the group programs may vary in effectiveness, their rapid spread indicates they may be responding to social needs not completely filled by families, churches, schools, or health and mental health professionals.

Helping to prevent suicide is a particularly important task.

Health professionals who see people at high risk—and the families and friends of such people— may be able to assist by carefully assessing their emotional status and providing, or referring them to, appropriate help.

Guns, alcohol, barbiturates and other drugs with lethal potential are used in a large proportion of suicide attempts. Their availability and use could be controlled more effectively.

Suicide also can be prevented by indirect means. Notably, in England, when the carbon monoxide content of gas piped to homes was reduced, suicides as well as accidental deaths dropped sharply. And while what had been the most common means of committing suicide was virtually eliminated, there was no compensating increase in suicide by other means.

A vital part of community strategy to reduce harmful stress consequences is to assure that people know about available services—and that services are truly accessible in terms of location and hours of operation. This applies to hotlines and sources of professional counseling as well as self-help and other supportive services.

For this, local media, telephone directories, churches, civic organizations, and other outreach channels can be used.

And there must be an effort to have services offered in ways that assure that no stigma attaches to their use.

Not least of all, there should be educational efforts by health professionals, schools, and all community groups and services to underscore the importance of the family as a potential resource for individuals trying to cope with stressful situations. How families develop communications between parents and children, offer support to a troubled member, and care for needs and views of family elders can either trigger or intensify stress on the one hand, or, on the other, help significantly to ameliorate it.

To be sure, stress is inevitable with living. But excessively stressful factors in the environment can be assessed; many can be reduced or removed; and families and educational, social service, and other support programs can help people cope effectively with those that remain.

Exactly how much can be achieved by strong, multi-faceted community programs to deal with stress is difficult to predict. But certainly it is important to test the extent to which such programs can reduce the individually and socially devastating effects of failure to cope adequately: homicides, suicides, substance abuse, accidental deaths and injuries, and disease.

Even relatively minor reductions would amply repay the investment.

• • • •

Collectively, smoking, misuse of alcohol and other drugs, poor dietary habits, lack of regular exercise, and stress place enormous burdens on the health and well-being of many Americans today.

Identifying and implementing ways to help people adopt more healthful habits will require a large commitment from government, schools, media, health professionals, and business and industry.

It will be necessary, too, to work to reduce pressures in our society which often lead people to adopt unhealthy habits.

Although helping people to understand the need for and to act to change detrimental lifestyles cannot be easy, the dramatic potential benefits clearly make the effort worthwhile.

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America in Transition: An Aging Society

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Introduction

One of the most significant demographic facts affecting American society is the aging of its population. The number of elderly persons has grown and, for the next 50 years, will continue to grow more rapidly than the total population. In 1982, 11 percent of all Americans were elderly (65 and older); by the year 2025, a projected 19 percent of the total population will be elderly.[1]

This report was originally prepared for the Senate Special Committee on Aging and is included as chapter 1 in the committee's report, *Developments in Aging: 1982, Volume 1*. This Census report presents a compendium of facts brought together to provide a readily usable profile of the demographic, social, and economic circumstances of the older members of American society.

Highlights of the report include:

- The 65 and over population grew twice as fast as the rest of the population in the last two decades.
- The 85 and over group is growing especially rapidly, up 165 percent from 1960 to 1982.
- The death rates of the elderly population, especially women, fell considerably over the last 40 years.
- The ratio of elderly to those under 65 will probably be 1 to 5 in 1990 and 1 to 3 in 2025.
- In 50 years, the ratio of people over 65 to people 18 to 64 will be almost three times as great as it was in 1950.
- The median income of elderly persons had a higher percentage increase over the last two decades than the median income of the younger adult population.
- Despite this improvement, about 1 of every 7 Americans over the age of 65 lives in poverty.
- Elderly women are almost twice as likely as elderly men to be poor; half of elderly widowed Black women live in poverty.
- About 8 in 10 persons 65 and over now describe their health as "good" or "excellent," compared with others of their own age.
- Elderly men are most likely to be married while elderly women are most likely to be widowed.
- The number of elderly women living alone has doubled in the last 15 years.
- During the last decade, the number of elderly persons living in central cities has declined, while the number living in the suburbs and small towns has increased.
- Half of those 65 and over who work now do so on a part-time basis as compared with a third 20 years ago.
- In the 1980 election, one-third of Americans who voted were 55 or older; 70 percent of those aged 55 to 74 voted.

"Aging" is a general term which can be defined as a physiological, behavioral, sociological, or chronological phenomenon. This report will use the chronological concept to look at the population 55 years and over on the assumption that the other aspects of aging tend to follow chronological age for large populations. When possible, the statistics will be distinguished for the "older" population (age 55 and over), the "elderly" (age 65 and over), the "aged" (75 years and over), and the "very old" (85 years and over).

[1] U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P-25, No. 952, *Projections of the Population of the United States, 1982 to 2080 (Advance Report)*. The projections used here are the "middle" series which assumes that fertility rates will remain steady, life expectancy will rise slowly, and net immigration will remain at 450,000 per year. The accuracy of the projections of the number of older Americans depends primarily on the accuracy of the mortality assumption; the accuracy of the percentage depends additionally on future birth rates, and thus we have less confidence in the proportions.

Numerical Growth

At the beginning of this century, about 7.1 million persons, less than 10 percent of the total U.S. population, were age 55 and over. In 1982, over one-fifth of the American population was 55 years old or over, an estimated 48.9 million persons. Of the total population, about 9.5 percent (22.1 million) were 55 to 64 years old, 7 percent (16.1 million) were 65 to 74 years old, 3.6 percent (8.2 million) were 75 to 84 years old, and 1.1 percent (2.5 million) were 85 years old and over. About 32,000 persons were aged 100 and over; about 60 percent of this group was female.

Projected Increases

Through the year 2000, the population age 55 and over is expected to remain at just over one-fifth of the total population. By 2010, because of the maturation of the baby boom group, the proportion of older to younger will rise dramatically—one-fourth of the total U.S. population (74.1 million) is projected to be at least 55 years old. One out of seven Americans are expected to be 65 and over (34.3 million) and the number of persons aged 85 and over could more than double to 6.8 million, 2.4 percent of the total population.

By the year 2030, it is likely that 1 out of 5 Americans will be 65 or older (64.3 million), which will represent an 87-percent increase in a 20-year span. At that same time, almost 3 percent of the population will be 85 or older (8.8 million). Finally, by 2050, nearly one-third of the population (104.3 million) is expected to be at least age 55.[3] So, while the total U.S. population is projected to increase by a third from its present size between 1982 and 2050, the older element—those persons age 55 and over—is expected to grow 113 percent (table 1, figure 1).

The age groups which require special attention—and which will experience dramatic increases in numbers—are the aged and the very old. Less than 5 percent of the population was 75 or older in 1982; by 2030, almost 10 percent of the population is projected to be in that age group. By 2050, the aged group is expected to be about 12 percent of the entire population. Meanwhile, the population aged 85 and over is projected to jump from about 1 percent in 1982 to over 5 percent of the total population in 2050. Figure 2 illustrates the dramatic increases in the number and proportion of the very old—from 123,000 in 1900, to 2.2 million in 1980, to a projected 16 million in 2050.

Overall, those 85 and over are projected to be the fastest growing part of the older population. In less than 30 years, the number of White males, White females, and Black males 85 years and over is expected to increase about 1½ times, while the number of Black women in that group is expected almost to triple. Because of the increasing number of persons who survive into their eighties, it is increasingly likely that older persons will themselves have a surviving parent.

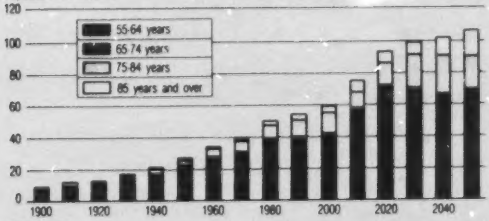
[3] Ibid.

TABLE 1.
Growth of the Older Population, Actual and Projected: 1900–2050
(Numbers in thousands)

Year	Total population all ages	55 to 64 years		65 to 74 years		75 to 84 years		85 years and over		65 years and over	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1900	76,303	4,008	5.2	2,189	2.9	772	1.0	123	0.2	3,084	4.0
1910	91,972	5,054	5.5	2,793	3.0	989	1.1	167	0.2	3,950	4.3
1920	105,711	6,532	6.2	3,484	3.3	1,259	1.2	210	0.2	4,953	4.7
1930	122,775	8,367	6.8	4,721	3.8	1,641	1.3	272	0.2	6,634	5.4
1940	131,888	10,572	8.0	6,375	4.8	2,278	1.7	365	0.3	9,017	6.8
1950	150,697	13,295	8.8	8,415	5.6	3,279	2.2	577	0.4	12,270	8.1
1960	179,323	15,572	8.7	10,997	6.1	4,630	2.6	929	0.5	16,560	9.2
1970	203,302	18,609	9.2	12,447	6.1	6,124	3.0	1,409	0.7	19,980	9.8
1980	226,505	21,700	9.6	15,576	6.9	7,727	3.4	2,246	1.0	25,544	11.3
1990	249,731	21,090	8.4	18,054	7.2	10,294	4.1	3,461	1.4	31,759	12.7
2000	267,980	23,779	8.9	17,669	6.6	12,267	4.6	5,136	1.9	35,036	13.1
2010	283,141	34,828	12.3	20,279	7.2	12,172	4.3	6,818	2.4	39,269	13.9
2020	298,338	40,243	13.6	29,759	10.0	14,290	4.8	7,337	2.5	51,386	17.3
2030	304,330	33,965	11.2	34,418	11.3	21,128	6.9	8,801	2.9	64,345	21.1
2040	307,952	34,664	11.3	29,168	9.5	24,529	8.0	12,948	4.2	66,643	21.6
2050	308,858	37,276	12.1	30,022	9.7	20,976	6.8	16,083	5.2	67,081	21.7

See appendix for source

FIGURE 1.
Population 55 Years and Over, by Age: 1900–2050
Population in thousands



See appendix for source

Impact of High Fertility Periods

It is commonly assumed that the current growth of the older population is due to increased longevity. The prime cause, however, is a steady increase in the annual number of births in the years prior to 1920. Increases in longevity are, in fact, only a secondary cause of this shift. From 1920 to 1940, there was a drop in the number of births, accounting for the projected slowdown in the growth of the older population from 1990 to 2010. The post-World War II baby boom accounts for the projected rapid rise in the number of elderly from 2010 until 2030. After that, the growth rate will slow again because of low birth rates during the "baby bust" period from 1965 to 1973. With continued improvements in mortality rates, the projections shown in table 1 will understate the projected size of the future older population.

Race and Ethnic Origin

The proportion of the population which is elderly varies considerably by race and ethnic origin. In 1982, about 12 percent of Whites, 8 percent of Blacks, 6 percent of Asians and Pacific Islanders, and 5 percent each of American Indians and Hispanics were 65 and over.[3]

Over the last decade, the elderly White population grew by about one-fourth, but the elderly Black population grew about one-third. The Black population has grown at a faster rate than the White population partly as a result of higher fertility levels and partly as a result of the more rapid gains in life expectancy experienced by Blacks than Whites. In 1900, the average life expectancy at birth was 18 years higher for Whites than for Blacks; by 1978, the difference had been reduced to 5 years.

In 1982, 8.5 percent of the population 55 years and over was Black (table 2); by 2050, Blacks are projected to make up over 14 percent of the older population. In 1982, White females 55 years and over constituted almost 11 percent of the total U.S. population, White males about 8 percent, Black women just over 1 percent, and Black men less than 1 percent.

Sex Differentials

Because the life expectancy of men is less than that of women, the health, social, and economic problems of the elderly, especially those over age 70, are mostly the problems of women. Old age is associated with "one-person (female) households, reduced income, increased poverty, and greater risk of ill-health, death, and institutionalization."[4]

[3] The discussion of minority elderly in this report is primarily limited to the Black population because of insufficient data on other minority elderly groups. The 1990 census figures on the characteristics of these populations will be available sometime in 1993.

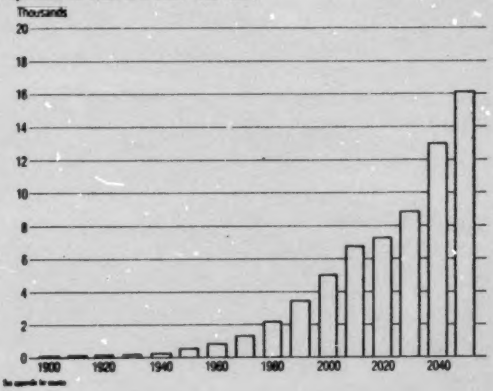
[4] Siegel, Jacob S., and Sally L. Hoover. *Demographic Aspects of the Health of the Elderly to the Year 2000 and Beyond.* World Health Organization, WHO/AGE/82.3, July 1982. Prepared for the World Assembly on Aging, July-August 1982, Vienna, Austria. p. 22.

TABLE 2.
Population 55 Years and Over, by Race and Sex: 1982
(Numbers in thousands)

Age (Years)		Total	White	Black	Other races
Total	55 and over	48,930	44,078	4,148	704
	55 to 64	22,086	19,780	1,953	353
	65 to 74	18,129	14,531	1,380	218
	75 to 84	8,239	7,495	646	98
	85 and over	2,466	2,272	169	24
Male	55 and over	21,105	19,043	1,737	325
	55 to 64	10,329	9,300	861	167
	65 to 74	6,996	6,318	576	102
	75 to 84	3,063	2,761	245	47
	85 and over	728	664	55	9
Female	55 and over	27,825	25,036	2,410	379
	55 to 64	11,758	10,480	1,092	186
	65 to 74	9,133	8,213	804	116
	75 to 84	5,186	4,734	400	52
	85 and over	1,738	1,608	114	15

See appendix for source.

FIGURE 2
Population 85 Years and Over: 1900–2050



See appendix for source.

Elderly women now outnumber men 3 to 2, a considerable change from 1960 when women outnumbered men by only 5 to 4. In 1982, there were 80 men aged 65 to 69 years for every 100 females in that same age group, and 42 men aged 85 and over for every 100 females aged 85 and over (figure 3). These statistics emphasize the fact that the older woman has a higher probability of living longer than the older man. Moreover, she is unlikely to remarry once she is widowed. The difference between the number of older men and women is significant within every age group.

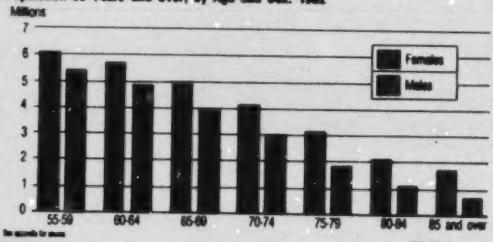
Life Expectancy

Based on the mortality experience of 1900, an individual born in that year could expect to live an average of 49 years. By 1954, life expectancy at birth had jumped to 70 years; by 1981, it almost reached 74. In 1930, only half of all babies were expected to live to age 65; by 1981, over three-fourths of all newborns could expect to reach that age. From 1940 to 1978, remaining life expectancy for males age 65 increased by only about 2 years (from 12.1 to 14 years), but for females it increased by almost 5 years (from 13.8 to 18.4 years) (figure 4).

Life expectancy at birth differs according to race (figure 5). In 1940, the difference between Whites and Blacks was 11 years; by 1978, the difference had been reduced to 5 years. Much of the difference has been attributed to socioeconomic status.[8] The difference between Blacks and

[8] Kitagawa, E.M., and P.M. Hauser. *Differential Mortality in the United States: A Study in Socioeconomic Epidemiology.* Cambridge, Harvard University Press, 1973 Chapters 2 and 8.

FIGURE 3.
Population 55 Years and Over, by Age and Sex: 1982



See appendix for source.

FIGURE 4.
Life Expectancy at Age 65: 1900–2050

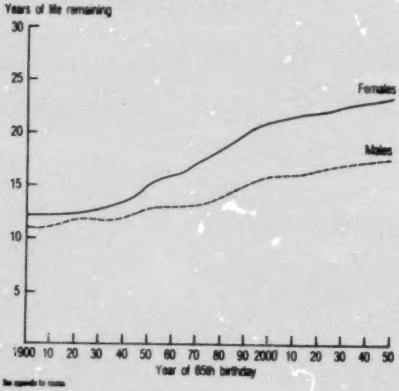


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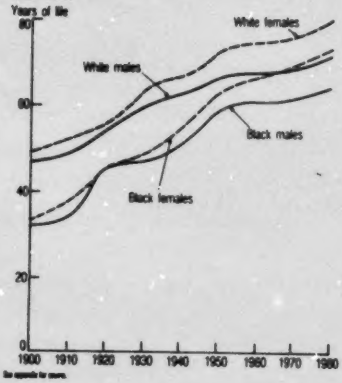
FIGURE 5.
Expectation of Life at Birth, by Race and Sex: 1900–1980



See appendix for source.

Whites in life expectancy at age 65, however, is small and has been for decades. In fact, death rates are higher for Whites after age 75 than for Blacks.

Dramatic changes in mortality rates have been registered since 1940. Mortality declined rapidly from 1940 to 1954, changed little from 1955 to 1967, and again declined rapidly from 1968 to 1978. While the death rates have fallen for both men and women, the rates have declined at a faster pace for women. In the 1968-78 period, the average annual rate of decline in the mortality rate for those 65 and over was 1.5 percent for males and 2.3 percent for females. The largest declines were for those 65 to 69 and for those 85 and over. The declines in this period were primarily due to a reduction in the mortality rates of major cardiovascular diseases.[6] Mortality differences among older males and females have steadily increased, from a difference in the age-adjusted death rates of 22 percent in favor of females in 1940 to a difference of 73 percent in favor of females by 1978.[7] Whether this difference is primarily due to environmental or genetic factors is not easily established.

Not only do mortality trends have major implications for the numbers and proportion of elderly in the future American population, but they also affect the health needs of the older population. Decreases in mortality rates do not translate into better health for all those living longer. Rather, the projected rapid increase in the size of the older population, particularly the very old, implies related increases in the demand for health care delivery and assistance. The projections for needed health care services are based upon the continuation of current mortality and utilization levels. If utilization rates decrease and if major diseases (especially heart diseases) are eliminated or delayed, the need for long-term care services and similar age-related health expenditures will decrease accordingly. However, if the onset of chronic disease were simply delayed and the duration is not shortened, health costs could exceed even currrent projections.

Relation to Working-Age Population

The combined effect of decreased fertility levels and increased numbers of elderly persons will result in growth in the ratio of elderly persons to persons of working age (18 to 64 years of age). In 1900, there were about 7 elderly persons for every 100 persons 18 to 64 years; by 1982, that ratio was almost 19 elderly persons per 100 of working age. By 2010, that ratio is expected to be 22 per 100 and to increase rapidly to 38 per 100 by 2050. This ratio is often referred to as a "support ratio." The ratio reflects the economic fact that the working population "supports" nonworking age-groups. The ratio reflecting those who have retired, as opposed to children, is especially important since it is primarily publicly funded programs which serve retirees. Moreover, the previously noted dramatic growth in the very old age group, with relatively greater health, social and economic needs will require proportionately higher levels of "support" than is true today (table 3, figure 6).

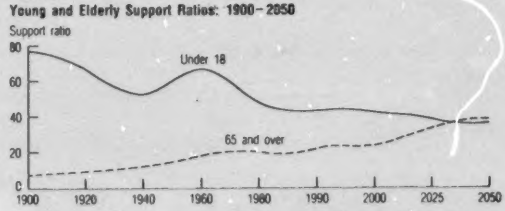
TABLE 3.
Total Support Ratio, Aged Support Ratio, and Young Support Ratio: 1900-2050
(Number of persons per 100 aged 18 to 64 years)

Support ratio	1900	1920	1940	1960	1980	1982[1]	1990	2000	2025	2050
Total support ratio (under 18 and 65 and over)	83.65	75.69	62.84	81.95	64.39	62.86	62.57	61.86	71.00	74.48
Aged support ratio (65 years and over)	7.35	7.99	10.90	16.84	18.58	18.82	20.70	21.16	33.31	37.86
Young support ratio (under 18)	76.30	67.70	51.94	65.11	45.80	44.04	41.87	40.70	37.69	36.61

[1] Based on estimates.

See appendix for source.

FIGURE 6.
Young and Elderly Support Ratios: 1900–2050



Note: "Young" support ratio is the number of persons under 18 per 100 aged 18 to 64 years. "Elderly" support ratio is the number 65 and over per 100 aged 18 to 64 years.

See appendix for source.

[6] Manton, Kenneth G., and Eric Stallard. "Temporal Trends in U.S. Multiple Cause of Death Mortality Data: 1968 to 1977." *Demography*, v. 19, No. 4, November 1982, pp. 527-547.

[7] U.S. Dept. of Health and Human Services, Public Health Service, National Center for Health Statistics. L. Fingerhut, *Changes in Mortality Among the Elderly, United States, 1940-1978*, Vital and Health Statistics, Series 3, No. 22, DHHS pub. No. (PHS) 892-1408, March 1982. Washington, U.S. Govt. Print. Off. pp. 2-6.

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Income and Poverty

The economic position of elderly persons is, in general, at a considerably lower level and is much less secure than that of the younger population. Only a minority manage to maintain relatively high incomes throughout their later years. Income is not a precise measure of economic well-being and simple comparisons of income between the older and younger population do not tell the whole story. For example, some older people have considerable assets (such as homes with high equity) but often these assets are not readily converted into cash and the annual incomes of older people are relatively low. Some older people, often those with good retirement plans, choose to accept the lower incomes associated with retirement so that they can enjoy more leisure time.

Lower incomes in the elderly population are associated with many factors over which elderly persons themselves have little control: their sex and race, the health and survival of their spouses, and their own health and ability to continue to work at acceptables wages. Other factors include the association of educational attainment and lifetime earnings and investments at younger ages for retirement. There is a strong pattern of declining income associated with advancing age. Older people who work full time tend to have incomes similar to younger persons of the same race and sex. For many elderly who do not work Social Security payments are vital. The paragraphs which follow discuss more specifically the factors which affect the income levels of elderly persons, the most important sources of income, and poverty levels.[4]

Age, race, and sex are significant factors in income level. Income tends to increase with age until about 55, when significant numbers of people begin to retire and a steady decline in income level begins (figure 7). For example, the median income in 1981 of men aged 60 to 64 years was about three-fourths that of men 15 years younger ($15,000 versus $21,000) but almost double that of men aged 65 and over ($8,200). The pattern for women is much the same, although the decline begins at age 50 and is at much lower levels. Elderly women had a median income in 1981 of $4,800, compared with about $7,000 for women aged 25 to 64 years. Three-fourths of the elderly had incomes below $10,000, compared with about 42 percent of those aged 25 to 64 years. About one-fourth of the younger group had incomes greater than $20,000, but only about 7 percent of the elderly were so wealthy. Incomes greater than $50,000 were received by not quite 1 percent of the elderly (219,000 out of the 25 million elderly with income), about half of whom were 65 to 69 years old (figure 8).

[4] Current data are from the March 1982 Current Population Survey and refer to money income in 1981 for the noninstitutionalized population only.

FIGURE 7

Median Income of Persons 25 Years and Over, by Sex and Age: 1981

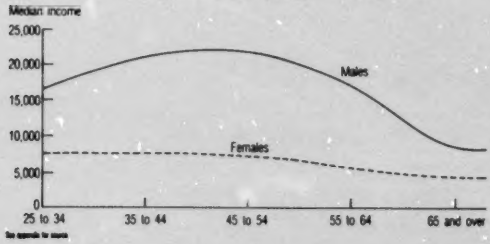

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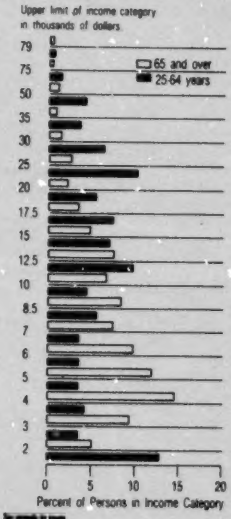
FIGURE 8

Income Distribution of Persons With Income 25 to 64 Years and 65 and Over: 1981



See appendix for source

While the income levels of most elderly persons are low in an absolute sense, as well as in comparison to the younger adult population, inflation did not affect the elderly population as much as the younger population.

Real median incomes of the elderly remained about constant from 1980 to 1981, a reflection in part of the indexing of many sources of retirement income to the Consumer Price Index. For the younger population, however, median income dropped a few percent from the 1980 level.

In 1972, a major "catchup" increase was enacted in Social Security benefits, and as a result, the median incomes of the elderly grew at about double the rate of those for younger people over the past decade. Using constant dollars, the median income of elderly persons has more than doubled since 1951 (table 4, figure 9).

TABLE 4.
Median Income of Persons 65 Years and Over: 1951–81
(In constant 1981 dollars)

Year	White: In current dollars	White: In 1981 dollars	Female: In current dollars	Female: In 1981 dollars
1981	$8,173	$8,173	$4,757	$4,757
1976	5,293	8,458	2,816	4,483
1971	3,449	7,745	1,708	3,831
1966	2,162	6,059	1,085	3,041
1961	1,758	5,345	854	2,596
1956	1,421	4,755	738	2,470
1951	1,008	3,529	536	1,877

See appendix for source

Within the elderly population, income differences between men and women and Whites and Blacks are striking. The income level of women, for all age groups, is much less than that of men of the same race. White men tend to have the highest median incomes and Black women the lowest. In 1981, elderly White men had median incomes of about $8,600; White women, $4,900; Black men, $4,900; and Black women, $3,500 (figure 10). Four out of five elderly Black women had incomes in 1981 less than $5,000, compared with about half of White women, and Black men and a fifth of White men. Contrary to the popular notion of the older rich widow, the statistics show that such women are a very small proportion of the elderly: out of 24 million older White women, only 86,000 had incomes greater than $50,000, and not all of these women were widows. As already indicated, the high-income elderly population is relatively small with White males by far the most likely to be in this group. Almost 9 percent of elderly White males had incomes greater than $30,000 in 1981, compared with 1 percent for White females and two-tenths of 1 percent for Black males and Black females.

Comparisons of income between elderly persons living alone and those living as part of a family or as part of multiperson households show that those living alone receive much less income. Some of the per-person difference is undoubtedly due to the fact that those not part of a family are older, and income usually declines with age. But much of the difference is due to the loss of a spouse and the alteration of stable and supporting living arrangements and the loss of income from work.

In 1981, there were 9.4 million families maintained by a person 65 years old or over. The median income of elderly families for that year was $14,335 (figure 11), much lower than that of younger families. But elderly families tend to be smaller than younger families, and when family size is taken into account, the median income of the elderly family was

FIGURE 9.
Median Income in Constant Dollars (1981), for Males and Females 65 Years and Over for Selected Years

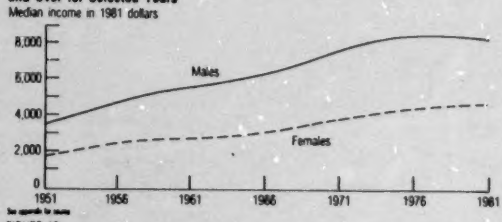


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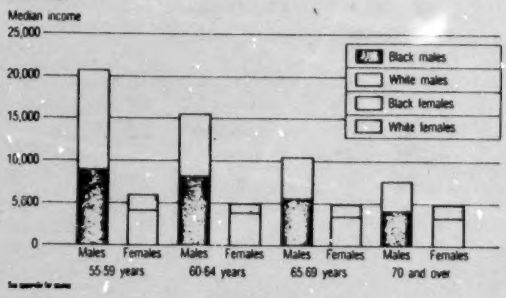
FIGURE 10
Median Annual Incomes of Persons 55 Years and Over, by Age, Race, and Sex: 1981



See appendix for source

about 90 percent of that of all families in 1981.

The relative position of elderly families has improved considerably since 1970 when they had a median income adjusted for family size of about 77 percent of that of all families. Much of this improvement is due to the 1972 one-time 20-percent increase and the cost-of-living increases in Social Security benefits which began in 1975.

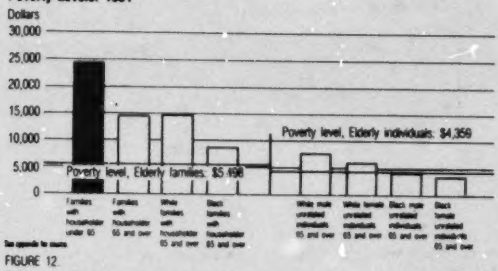
Even when family size is considered, there are a substantial number of elderly families with incomes at the lowest economic levels as compared with younger families. Among families maintained by an elderly person in 1981, 3 out of 10 had incomes less than $10,000 5 had incomes between $10,000 and $25,000, and 2 had incomes greater than $25,000.

The difference in the income level of Black families and White families was considerable. The income of elderly Black families in 1981 was about 44 percent of that of elderly White families when adjusted for average family size. The relative differences were even greater when the family was maintained by a woman with no husband present.

While elderly married couples had economic resources approaching those of their sons and daughters, the picture is much different for the divorced, widowed, and others not living in families (figure 12). There were 8.1 million elderly "unrelated individuals" in 1981, most of whom lived alone and some of whom lived with persons other than their relatives. Elderly unrelated individuals had a 1981 median income of $5,771, which was less than two-thirds that of unrelated individuals of all ages, a relative position that was also true in 1960. The median income of those who lived alone was $5,134. Single women were the most likely to have the lowest incomes and to be poor. One-fourth of elderly unrelated individuals had incomes less than $4,000, another fourth had incomes between $4,000 and $6,000, and still another fourth had incomes between $6,000 and $10,000. The remaining quarter had incomes greater than $10,000, with 6 percent having incomes greater than $20,000. For unrelated individuals under age 65, about 70 percent had incomes greater than $10,000.

FIGURE 11

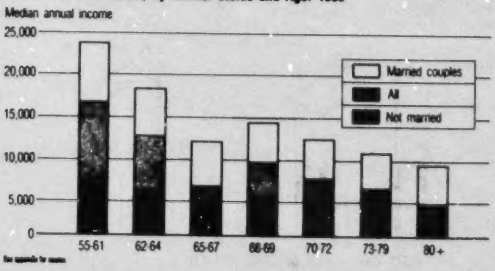
Median Income of Families and Individuals, by Age and Race, Compared to Poverty Levels: 1981



See appendix for source.

FIGURE 12

Median Annual Income, by Marital Status and Age: 1981



See appendix for source.

Sources of Income

Social Security benefits are the single largest source of money income for the elderly, and the single source on which the largest proportion is most dependent. Social Security benefits reach 91.2 percent of the elderly population, and for over half, the benefits constitute over half of their income. For some, Social Security is vital: a fifth of the total elderly population and two-fifths of Blacks living alone received virtually all (90 percent or more) of their income from Social Security.

While Social Security accounted for 37 percent of the total money income of elderly persons in 1981, earnings accounted for 26 percent, property income (mainly rents, dividends, and interest) for 23 percent, and private and

public pensions for 13 percent (figure 13). A recent study by the Social Security Administration showed that one of the most significant changes in the source of income for the elderly since the 1960's was a decline in the importance of earnings and increased reliance on retirement income from Social Security, public and private pensions, and assets.[9] Social Security income also increases in relative importance as a person ages.

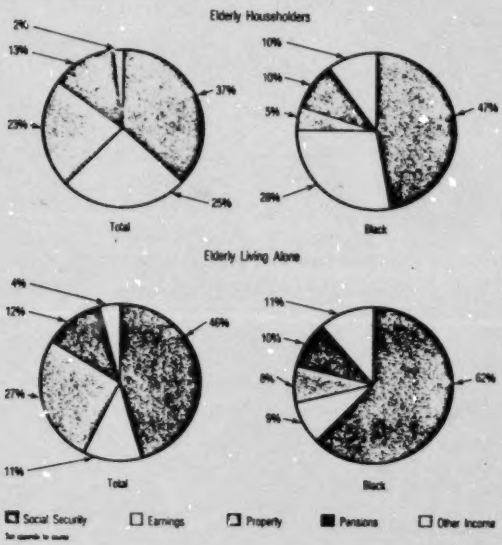
[9] U.S. Dept. of Health and Human Services. Social Security Administration. Melinda Upp, "Relative Importance of the Aged, 1980," *Social Security Bulletin*, V. 46, No. 1, January 1983, pp. 9-10.

Earnings, property income, and pensions are less universal than is Social Security and are of varying significance. For example, most of the elderly who reported property income in 1978 received less than $1,000 from that source, and most receiving pensions got less than $2,000. While private pensions are now more likely to be received than in the past, in 1981 only 2 percent of the elderly relied on pensions for at least half of their total income.

Earnings make the greatest difference in the economic position of older persons. Those who are year-round, full-time workers have incomes close to those of younger people until the age of 70 when the median income dropped from $19,000 to $16,000. In 1981, about 8.9 million persons 55 to 64 years old worked full time and year round (41 percent of the total); about 800,000 (10 percent) 65 to 69 years old and about 400,000 (2 percent) 70 years and over worked full time and year round. The likelihood of continuing to work after one becomes eligible for retirement is related to the ability to make more from work than from Social Security or pension benefits: half of the elderly who worked year round and full time had incomes between $10,000 and $30,000. It is also likely that the health of those with higher earnings is good, which allows them to make a choice about working.

FIGURE 13.

Source of Money Income in 1981, by Race, for Elderly Householders and Persons Living Alone: 1981



See appendix for source

Poverty: Cash Income

For the first time in their lives, many persons face poverty as they age, particularly after retirement. One out of seven elderly persons (15.3 percent or 3.9 million) lived in poverty in 1981 (table 5), the same proportion as in 1975. This rate is a signifi-

TABLE 5.

Percentage of Persons 65 Years and Over in Poverty: 1959–81

Characteristic	1959	1970	1980	1981
Persons under 65	20.9	11.3	12.7	13.9
Persons 65 and over	35.2	24.6	15.7	15.3
In families	26.9	14.8	8.5	8.4
Householder	29.1	16.5	9.1	9.0
Male	29.1	15.9	8.2	8.9
Female	29.8	20.1	15.2	18.0
Other family members	24.6	13.0	[2]7.6	7.6
Unrelated individuals	61.9	47.2	30.6	29.8
Male	59.0	38.9	24.4	23.5
Female	63.3	49.6	32.3	31.4
White	33.1	22.6	13.6	13.1
Black	62.5	47.7	36.1	38.0
Hispanic	(1)	(1)	30.8	25.7
Metropolitan	26.9	20.0	12.9	12.6
Nonmetropolitan	47.0	31.5	20.5	19.9

[1] Not available

[2] Other family members in families with married couples only; the 1980 figure for other family members in families without married couples was 8.7 percent.

See appendix for source

cant change from 1970, when 1 out of 4 elderly persons lived in poverty, and from 1959, when more than a third had incomes below the poverty level.

Poverty rates are highest among the aged, women, minorities, those who live alone, and among those who are not married, do not work, depend exclusively on Social Security benefits, and live in small towns and rural areas.

In 1981, there were 17.3 million elderly households and their poverty rate was 18 percent; if the "near poor" (money incomes below 125 percent of the poverty level) are included, the poverty rate for this population was closer to 30 percent.

Poverty rates increase sharply with age, partly because of the substantial reductions in income as a result of retirement and partly because of the likelihood of major expenditures for health care. The poverty rate for those aged 60 and 61 was about 10 percent in 1981 but jumped to nearly 18 percent for those aged 72 and over.[19]

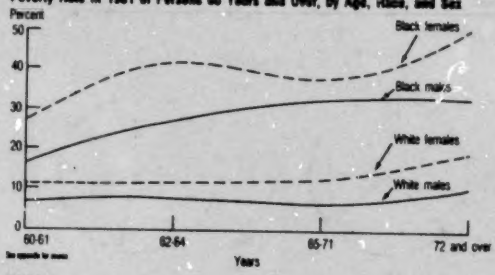
Poverty is also disproportionately high among women and Blacks. Elderly White men had a poverty rate of 8.5 percent in 1981, but elderly White women were twice as likely as their male counterparts to be in poverty, Black men four times as likely, and Black women five times as likely (figure 14).

Poverty rates tend to be lower for those who are married than for those who are widowed, single, divorced, or separated. For example, one-fourth of older Black women who are married are poor, but one-half of the widows are poor. Those who are not married generally live alone; 29 percent of those who lived alone also lived in poverty, compared with 8 percent of those who lived in families. Of all poor people 60 years and over, over half lived alone. This was especially true of women 60 years and over; about two-thirds of poor White women lived alone as did over half of poor Black women. Black women living alone had the highest poverty rates, twice as high as those of White women living alone (figure 15).

Of all poor persons 60 years and over, just over half lived in metropolitan areas and the remainder lived in small towns and rural areas (non-metropolitan). The poverty rate in 1981 for those who lived in metropolitan areas was 11.5 percent. But for those who lived in the small towns outside of metropolitan areas and in rural areas, the poverty rate was 18.8 percent; for aged Black women in those areas, it was over 60 percent.

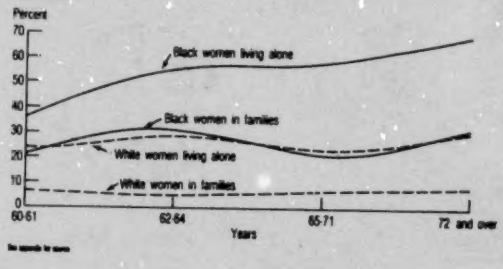
The incidence of poverty is closely associated with the type of income a person has. The lowest poverty rates were reported for older persons who had wage and salary income (4 percent), while over 30 percent of those who had only Social Security income were poor in 1981.

FIGURE 14.
Poverty Rate in 1981 of Persons 60 Years and Over, by Age, Race, and Sex



See appendix for source.

FIGURE 15.
Poverty Rate in 1981 of Women 60 Years and Over, by Living Arrangements and Race



See appendix for source.

[19] U.S. Dept. of Commerce, Bureau of the Census, *Money Income and Poverty Status of Families and Persons in the United States: 1981*, Current Population Reports, Series P-60, No. 134, July 1982, table 15, p. 22.

Of the 5 million persons 60 years old and over who were poor in 1981, less than 500,000 worked and only about a fourth of those worked full time and year round. Those who worked all year had poverty rates about half the rate of those who worked part of the year and about a fourth of those who did not work at all during the year. Of those poor who worked only part of the year, over one-quarter said they did not work a full year because they were ill or disabled, and about 1 in 7 said they could not find work. Of those poor who did not work at all during the year, a third said they could not work because they were ill or disabled and 40 percent said they were retired.

Although over 1 in 7 elderly persons had an income below the poverty level in 1981, only about 1 in 9 received cash income from public assistance. For one-third of such recipients (or 1 in 27 persons over 65), public assistance provided more than half of their income.[15]

Poverty levels vary widely by State, as do the relative poverty levels for the elderly as compared with the younger population. According to the 1980 census, the poverty rates for the elderly in most States in 1979 were slightly higher than the poverty rate for all persons. The exceptions included New York, Arizona, California, and Florida. In the latter three "Sunbelt" States, the lower poverty rates for persons 65 years old and over may be related to the presence of substantial numbers of relatively well-to-do retirees who have migrated from other States.

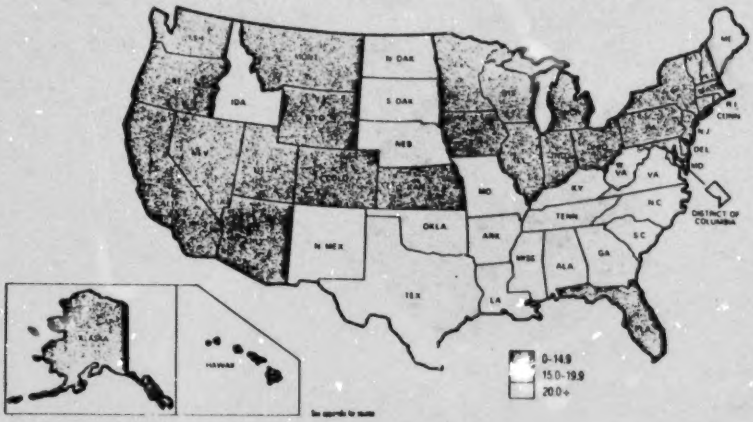
[15] U.S. Dept. of Health and Human Services, Social Security Administration, Office of Policy, Office of Research and Statistics, *Income and Resources of the Aged, 1978*, Social Security Publication, No. 13-11727, October 1981.

The highest 1979 poverty rates for the aged were found in Mississippi (34.3 percent), Alabama (28.4 percent), and Arkansas (28.2); the States with the lowest rates were California, Connecticut, and Wisconsin (8.3, 8.8, and 9.6 percent, respectively).

Poverty: Noncash Benefits

In-kind public transfers in the form of food (food stamps), housing (publicly owned or subsidized rental housing), and medical care (Medicare and Medicaid) have expanded markedly in the last decade. The current government definition of poverty, however, is based on money income only and does not include the value of in-kind transfers as income. If the value of in-kind food, housing, and medical care transfers received by the low-income elderly population were

FIGURE 16
Percentage of Persons 65 Years and Over With Incomes Below Poverty Level in 1979



regarded as money income, the poverty rate would change.

A recent study determined that the various methods used to value in-kind benefits resulted in a large range of poverty rates depending on the methodology used and the type of benefits included.[13] Estimating the value of noncash benefits is difficult and controversial. Considering money income only, the poverty rate for elderly persons in 1979 was 14.7 percent. Using market values, if food and housing benefits were included, the poverty rate would have been reduced—but only to 12.9 percent. Adding the market value of medical benefits, including institutional care, reduced the poverty rate significantly, but there is serious disagreement over the inclusion of medical care—especially institutional care—for determining poverty status. Except for Medicare, most of the noncash benefits received by elderly households were means-tested; i.e., income criteria determined eligibility. Of the 1.1 million elderly households that received food stamps in 1981, 86 percent had incomes below 125 percent of the poverty level and received food stamps with a mean face value of less than $500 annually. About 949 000 (5 percent) elderly households lived in Government-subsidized housing. About 2.5 million (14 percent) elderly households received Medicaid benefits, and, in 16.8 million elderly households, Medicare covered at least one person. Elderly households made up approximately 1 out of 6 households receiving food stamps, about 1 in 3 of the households in public or otherwise-subsidized housing, and 30 percent of those who received Medicaid.[13]

The persistence of relatively high rates of poverty among the elderly despite the enormous sums devoted in the Federal budget for elderly program recipients ($197 billion in fiscal year 1982) presents a paradox. Basically, there are three explanations for this seeming paradox.

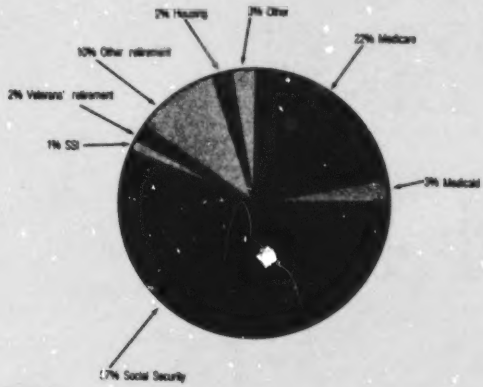
First, a large portion of elderly persons with incomes below the poverty line do not participate in the means-tested programs designed to assist them. In fact, nearly half (49 percent) of elderly households in the poverty category received neither cash nor in-kind assistance from means-tested programs.

Second, of the approximately $200 billion spent for the elderly, the overwhelming portion is committed to social insurance programs (figure 16). These certainly aid many low-income

[13] U.S. Dept. of Commerce, Bureau of the Census, Technical Paper No. 50, *Alternative Methods for Valuing Selected In-Kind Transfer Benefits and Measuring Their Effect on Poverty*, Washington, U.S. Govt. Print. Off., 1982.

[13] U.S. Dept. of Commerce, Bureau of the Census, *Characteristics of Households Receiving Selected Noncash Benefits: 1981 (Advance Data from the March 1982 Current Population Survey*, Current Population Reports, Series P-60, No. 135, Washington, U.S. Govt. Print. Off., 1982, tables B, C, and I.

FIGURE 17
Federal Outlays Benefiting the Elderly: Fiscal Year 1982



See appendix for notes.

elderly persons, but they are not, by definition, programs targeted at the poverty population. Instead, the social insurance programs are earned entitlements which make benefits available to all those who qualify on the basis of age and other factors. An analysis of fiscal year 1982 Federal budget expenditures reveals that 92 percent of the total spent on elderly persons was allocated to retirement and health insurance programs that are largely self-funded through lifetime contributions from individuals and employers. Less than $16 billion, or 2.1 percent of the entire budget, was spent to assist low-income elderly persons through cash or in-kind means-tested programs.

The third reason that poverty among the elderly persists despite the current level of Federal spending is that the principal means-tested programs, such as Supplemental Security Income, pay maximum benefits which are below the poverty level.

Health Status

Contrary to the stereotype, the older population as a whole is healthier than is commonly assumed. In 1980, 9 or 10 elderly persons described their own health as fair, good, or excellent as compared with others of their own age; only 8 percent said their health was comparably poor.[15] About 40 percent of the elderly population reported that, for health reasons, a major activity had been limited (compared with about 20 percent of the population 45 to 64 years), but 54 percent reported no limitations of any kind in their activities.[16] Not until age 85 and over do about half of the population report being limited or unable to carry on a major activity because of a chronic illness.[16]

Good health is associated with higher incomes: 40 percent of those with incomes over $25,000 described their health as excellent as compared with others of their own age, but less than a quarter of those with low income (less than $7,000) reported excellent health.[17]

Persons 65 years and over have about twice as many days of restricted activity due to illness as the general population (almost 40 days versus 19 in 1981). But those elderly who worked do not experience a marked difference in the number of lost work days—about 4 or 5 days a year, on the average, for both the younger and older working population.[18]

The very old do have more need for assistance that the younger-old. For instance, in 1978, less than 1 percent of the noninstitutional population 65 to 84 years needed help in eating, while about 4 percent of the population 85 and over did; about 7 percent of the very old needed help toileting versus less than 2 percent of the younger-old; 11 percent of the 85 and over group needed help dressing, and 18 percent needed help bathing, while the figures were about 3 and 4 percent, respectively, for the 65- to 84-year-old group. Based on these functional measures, more than 90 percent of the noninstitutionalized very old were able to take care of their own daily needs.[19]

The rural elderly are the most likely to have chronic health conditions that limit their activities. In the South in the 1973-74 period, 53 percent reported a chronic problem as compared with 43 percent of metropolitan elderly and 48 percent of all nonmetropolitan elderly. Duration of illness is higher for the nonmetropolitan elderly who reported 39 days per person per year of restricted activity (52 days in the nonmetropolitan South) as compared with 34 days in metropolitan areas. Thus, the nonmetropolitan elderly, because of the incidence and duration of chronic conditions, are more likely to require assistance, even though it is less available to them than to their healthier counterparts in metropolitan areas.

Despite relatively stable overall health status over the past 15 years, health expenditures by elderly persons continue to climb faster than increases in either income or the overall inflation rate. Health-care expenditures not covered by Medicare now equal an average of 19.9 percent of all yearly income for those 65 and over. Even with the assistance of Federal health insurance programs, elderly persons are now paying an average of 29 percent of their total annual health bills out-of-pocket—a greater proportion than they were before the enactment of Medicare and Medicaid.[20]

Morbidity Trends

The pattern of chronic morbidity has changed in the past 80 years. Whereas acute conditions were predominant at the turn of the century, chronic conditions are now the most prevalent health problem for elderly persons. There has also been a change in the pattern of illness within one's lifetime. That is, as people age, acute conditions become less frequent and chronic ones more prevalent. The likelihood of having a chronic illness or disabling condition increases dramatically with age. Over 80 percent of persons 65 and over have at least one chronic condition, and multiple conditions are commonplace for the elderly.

Even though there has been significant improvement in death rates, measures from the Health Interview Surveys from 1965 (the first year of the survey) through 1979 do not show

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[15] U.S. Dept. of Health and Human Services, Public Health Service, National Center for Health Statistics, 1980 Health Interview Survey, publication forthcoming.

[16] U.S. Dept. of Health and Human Services, Public Health Service, National Center for Health Statistics, B. Bloom, *Current Estimates from the National Health Interview Survey, United States, 1981*, Vital and Health Statistics, Series 10, No. 141, DHHS Publication No. (PHS) 83-1569, Washington, U.S. Govt. Print. Off., October 1982, table 14, p. 24.

[17] U.S. Dept. of Health and Human Services, Federal Council on Aging, *The Need for Long Term Care: Information and Issues*, DHHS Publication No. (OHDS) 81-20704, Washington, U.S. Govt. Print. Off., pp. 27-28.

[18] U.S. Dept. of Health and Human Services, Public Health Service, National Center for Health Statistics, publication forthcoming, op. cit.

[19] U.S. Dept. of Health and Human Services, Public Health Service, National Center for Health Statistics, Current Estimates from the National Health Interview Survey, United States, 1981, op. cit., table 12, p. 22.

[20] U.S. Dept. of Health and Human Services, Federal Council on Aging, op. cit., pp. 27-28.

[20] U.S. Congress, Senate, Health Care Expenditures for the Elderly: How Much Protection Does Medicare Provide, 97th Cong., 2d Sess., Prepared by the Staff of the Senate Special Committee on Aging, Washington, U.S. Govt. Print. Off., April 1972.

any major improvements in the health status of the elderly. In the early part of this century, infectious and parasitic diseases were the major causes of illness among the group. Now, however, the major causes are chronic diseases, accidents (especially traffic accidents), and stress-related conditions.[21] The leading chronic conditions causing limitation of activity for the elderly in 1979 were arthritis and rheumatism, heart conditions, hypertension without heart involvement, impairments of the lower extremities and hips, and impairments of the back or spine. The first two conditions accounted for half of the total in 1979.[22] Stress-related conditions include hypertension, attempted suicide, and drug dependency. The principal diagnoses made by doctors for the elderly in the 1980-81 period were hypertension, diabetes, chronic ischemic heart disease, cataracts, and osteoarthritis.[23]

The diseases which affect elderly men predominate as causes of death, while those which effect elderly women predominate as causes of illness. The health situation of elderly Blacks is generally poorer than that of elderly Whites. For example, hypertension was more prevalent among Blacks 65 to 74 years old (45 percent) than among Whites (33 percent) in the 1971-75 period.[24]

[21] Omran, Abdel R. *Epidemiological Transition in the United States: The Health Factor in Population Change.* Population Bulletin, v. 32, No. 2, May 1977. Washington, Population Reference Bureau, Inc.

[22] U.S. Dept of Health and Human Services. Public Health Service. National Center for Statistics. *Limitations of Activity Due to Chronic Conditions, United States, 1974.* Vital and Health Statistics, Series 10, No. 111, June 1977.

[23] U.S. Dept of Health and Human Services. Public Health Service. National Center for Health Statistics, unpublished.

[24] U.S. Dept of Health and Human Services. Public Health Services. National Center for Health Statistics. *Limitations of Activity Due to Chronic Conditions,* op. cit.

Medical Care

With a greater prevalence of chronic conditions than the population at large, older persons utilize medical personnel and facilities somewhat more frequently than do younger people. Persons 65 and over average 6 doctor visits for every 5 made by the general population. The elderly are hospitalized approximately twice as often as the younger population, stay twice as long, and use twice as many prescription drugs.

Since 1965, the year Medicare was enacted, elderly persons have increased their use of short-stay hospitals by more than 50 percent versus an 11 percent increase for the total population. The hospital discharge rate for the very old is over 75 percent higher than that for the 65- to 74-year-old group. The average hospital stay for persons under age 65 was about 6 days, compared with almost 12 days for those 85 years and over.[25]

Mental Health

A destructive age-related stereotype is that senility is inevitable in old age and that it is the rare aged individual who is not in some state of mental deterioration. In fact, the term "senility" has been used generally to describe any number of symptoms and diseases, many of which are treatable. Estimates for the 1976-79 period indicate that from 15 to 25 percent of the elderly in the community may have significant symptoms of mental illness. It is estimated that for about 10 percent, these symptoms may be due to depression, and for 5 to 6 percent, to senile dementia. Among nursing home residents, about 56 percent suffer a chronic mental condition or form of senility. Even though the elderly apparently suffer significant mental health problems, many of which could be treated, the older population uses mental health services at only about half the rate of the general population—7 versus 16 admissions per 1,000.[26] One trend has been the shift of older persons out of the mental health system and into nursing homes. From 1969 to 1973, the number of nursing home residents with diagnosed mental health problems doubled to a total of 194,000.[27]

Institutionalization

Contrary to popular assumptions, tions, only about 5 percent of the

[25] U.S. Dept of Health and Human Services. Federal Council on Aging. op. cit., pp. 39-41.

[26] Ibid., pp. 32-33, 38.

[27] Ibid., pp. 46-47.

TABLE 6.

Population 65 Years and Over in Nursing Homes, by Age

(Numbers in thousands)

Age (years)	1963	1973	1977	1982[1]
65 and over	448	961	1,126	1,316
65 to 74	93	159	211	232
75 to 84	207	384	485	527
85 and over	148	408	450	557

[1] Based on 1982 estimate and proportion of the population for each age group in nursing homes in 1977: 65 and over, 0.049; 65 to 74, 0.0144; 75 to 84, 0.064; 85 and over, 0.2259.

See counts in text.

TABLE 7.

Death Rates and Percentage of Total Deaths for the 10 Leading Causes of Death for Persons 65 Years and Over: 1979

(Rates per 100,000 population 65 years and over)

Rank[1]	Cause of death[2]	Rate	Percent of total deaths
	All causes	5,157.2	100.0
1	Diseases of heart	2,299.1	44.6
2	Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues	1,005.4	19.5
3	Cerebrovascular diseases	587.6	11.4
4	Chronic obstructive pulmonary diseases and allied conditions	138.1	3.0
5	Pneumonia and influenza	148.4	2.9
6	Atherosclerosis	111.6	2.2
7	Accidents and adverse effects	97.5	1.9
	Motor vehicle accidents	23.9	3.5
	All other	73.6	1.4
8	Diabetes mellitus	97.1	1.9
9	Nephritis, nephrotic syndrome, and nephrosis	48.5	0.9
10	Chronic liver disease and cirrhosis	38.3	0.7
	All other causes	570.4	11.1

[1] Rank based on number of deaths.
[2] 9th Rev. International Classification of Diseases, 1975.

See appendix for source.

TABLE 8.

Gain in Expectation of Life at Birth Due to Elimination of Specified Causes of Death: 1969-61, 1969-71, 1979

Cause of death	Total population			White male			White female		
	1969-61	1969-71	1979	1969-61	1969-71	1979	1969-61	1969-71	1979
1. Tuberculosis, all forms	.10	.04	.02	.10	.03	.02	.05	.02	.01
2. Infective and parasitic diseases	.22	.17	.17	.20	.13	.14	.14	.12	.14
3. Malignant neoplasms of digestive organs and peritoneum	.86	.80	.71	.83	.56	.03	.68	.62	.72
4. Malignant neoplasms of respiratory system	.32	.50	.73	.49	.69	.92	.11	.22	.43
5. Malignant neoplasms	2.27	2.47	3.08	2.12	2.31	2.85	2.43	2.57	3.12
6. Diabetes mellitus	.22	.24	.22	.15	.17	.15	.37	.39	.25
7. Diseases of the heart	5.89	5.86	7.01	6.51	6.14	8.40	5.04	5.17	6.94
8. Cerebrovascular diseases	—	1.19	1.14	—	.86	.74	—	1.36	1.42
9. Arteriosclerosis	.18	.13	.18	.15	.08	.10	.21	.17	.21
10 Influenza and pneumonia	.53	.47	.39	.48	.41	.33	.42	.40	.39
11. Bronchitis, emphysema, and asthma	—	.20	.14	—	.26	.17	—	.10	.10
12. Diseases of the respiratory system	—	.83	.84	—	.86	.85	—	.81	.71
13. Peptic ulcer	.09	.06	.04	.11	.08	.04	.06	.04	.03
14. Cirrhosis of liver	.19	.28	.27	.22	.30	.29	.13	.20	.18
15. Nephritis and nephrosis	—	.07	.06	—	.05	.05	—	.06	.05
16. Congenital anomalies	.36	.29	.25	.37	.30	.25	.36	.30	.25
17. Certain diseases of early infancy	1.12	.82	.49	1.12	.82	.44	.90	.68	.37
18. Motor vehicle accidents	.55	.70	.65	.78	.93	.89	.30	.41	.39
19. All other accidents	.62	.63	.58	.77	.76	.69	.35	.35	.33
20. Suicide	.22	.28	.30	.31	.34	.42	.12	.18	.18
21. Homicide	.13	.23	.26	.09	.16	.22	.04	.08	.09

See appendix for source.

elderly population live in nursing homes. In 1982, an estimated 1.3 million elderly persons resided in nursing homes. An estimated 1.5 percent (232,000) of those aged 65 to 74 years old were in a nursing home as compared with about 6 percent (527,000) of those aged 75 to 84 years, and only about 23 percent (557,000) of those 85 and over (table 6). The rate of nursing home use by the elderly has almost doubled since the introduction of Medicare and Medicaid in 1966, from 2.5 to 5 percent of the over-65 population. Almost three-fourths of nursing home residents are without a spouse as compared with just over 40 percent of the noninstitutionalized elderly. Such statistics, along with those which show that nursing home residents tend to have health problems which significantly restrict their ability to care for themselves, suggest that the absence of a spouse or other family member who can provide informal support for health and maintenance requirements is the most critical factor in the institutionalization of an older person. It is likely that the nursing home population will continue to grow rapidly, partly because of the rapid growth in the size of the very old population, and partly because of the increasing gap in life expectancy between husbands and wives.[38]

Mortality

In the United States, 3 out of 4 elderly persons die from heart disease, cancer, or stroke (table 7). Heart disease was the major cause of death in 1950 and remains so today even though there have been rapid declines in death rates from heart diseases since 1968, especially among females. Death rates from cancer have con-

[38] Ibid., pp. 42-43.

tinued to rise since 1900, especially deaths caused by lung cancer. Cancer accounted for about a fourth of all deaths for those aged 65 to 74 years, a little less than a fifth of the deaths for the 75- to 84-year-old group, and about 10 percent for the very old.[59] Even if cancer were eliminated as a cause of death, the average lifespan would be extended by only 2 to 3 years (table 8) and more would then die from heart disease. Eliminating deaths due to major cardiovascular-renal diseases would add an average of 11.4 years to life at age 65, and would lead to a sharp increase in the proportion of older persons in the total population.[59] The third leading cause of death among the elderly, stroke, has been a decreasing factor since 1968.

The factors which have led to reductions in mortality may or may not also lead to reductions in morbidity. If we continue to live only to about age 85 such changes could produce a healthier older population, but if we survive in future years, on average, beyond the age of 85, they could also mean a delay in the onset of illness without an actual shortening of the period of illness.[61]

[59] U.S. Dept. of Health and Human Services. Public Health Service. National Center for Health Statistics. *Health: United States, 1981*, pp. 17-19.

[60] U.S. Dept. of Health and Human Services. Public Health Service. National Center for Health Statistics. *U.S. Life Tables by Cause of Death: 1969-1971, U.S. Decennial Life Tables for 1969-1971*, v. 1, No. 5, 1976.

[61] *Health: United States, 1981*. Ibid., pp. 20-23.

Social and Other Characteristics

Geographic Distribution

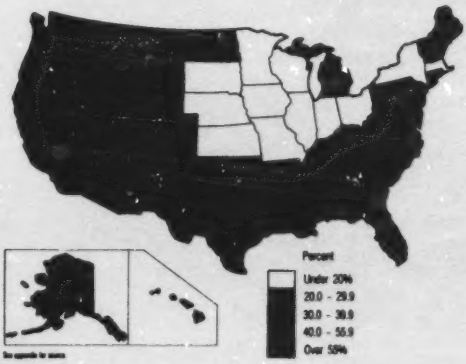
In 1981, as was true a decade earlier, almost two-thirds of the elderly population lived in metropolitan areas (standard metropolitan statistical areas); of that group, just over half lived outside the central city, a reversal from 1970, when more lived inside the central city. Elderly persons are less likely to live in the suburbs than are persons under age 65 (34 versus 41 percent). Of the elderly population living in nonmetropolitan areas, 3 out of 4 lived in counties that did not have towns as large as 25,000. The White, Black, and Hispanic elderly are all more likely to live in metropolitan areas than in nonmetropolitan areas. White elders are more likely to be suburban dwellers, whereas Black and Hispanic elders are more concentrated in the central cities. A decreasing proportion of persons 65 and over lived in farm areas, 3 percent in 1980, compared with almost 4.5 percent in 1970.

Even though most elderly live in metropolitan areas, they constitute about 10 percent of the metropolitan population, compared with about 12 percent of the nonmetropolitan population. About 45 percent of the Nation's nonmetropolitan elderly live in the South, while the Northeast and West combined have only about 25 percent. Growth of the elderly population in small towns and rural areas has been about 2.5 percent annually in recent years, a somewhat higher growth rate than that for the total older population.[33]

In 1980, there were seven States with more than 1 million persons 65 years and over: California (2.4 million), New York (2.2 million), Florida (1.7 million), Pennsylvania (1.5 million), Texas (1.4 million), Illinois (1.3 million), and Ohio (1.2 million). With the inclusion of Michigan, almost half of the total elderly population of the United States is accounted for in these eight States. Alaska had the smallest number of elderly persons—only 11,500—less than 3 percent of its total population. Florida is the State with the largest proportion of over 65's in the population—17.3 percent. Arkansas, Rhode Island, Iowa, Missouri, South Dakota, Nebraska, and Kansas followed with 13 to 14 percent. The largest percent increases in the elderly population over the decade were in the South and West. Most States had at least a 50-percent increase in the number of persons 65 and over in the last decade, while Arizona, Florida, and Nevada more than doubled the size of their very old population.

[33] U.S. Congress. Senate. Special Committee on Aging. Calvin L. Beale, Rural Older Americans: Unanswered Questions. Hearing, 97th Cong., 2d Sess. May 19, 1982. Washington, U.S. Govt. Print. Off.

FIGURE 18
Percent Increase in State Populations Aged 65 and Over: 1970 - 80



See appendix for source.

The traditional notion of Florida as the State with the greatest concentration of elderly persons is borne out by the statistics. The three large metropolitan areas in 1980 with the greatest proportion of elderly in the United States were all in Florida: Fort Lauderdale-Hollywood (22.0 percent), Tampa-St. Petersburg (21.4 percent), and Miami (15.7 percent). These three metropolitan areas also had the largest proportions 75 and over (7 to 8 percent), and over 85 (1.3 to 1.7 percent); these proportions however, were not much above the national average. The smallest proportion of metropolitan elderly were in Houston, Texas, with less than 7 percent elderly. Only the New York metropolitan area had over 1 million elderly residents.

Residential Mobility

Most older persons remain in the same place where they spent most of their adult lives. With increasing age, people move less often. The older population who moved from one

house to another did so at about half the rate of the population of all ages. Between 1975 and 1980, about one-fourth of the population 55 to 64 years old moved, and about one-fifth of the entire elderly population moved, compared with 45 percent of the population age 5 and over.

While about 9 percent of the population age 5 and over relocated to a different State, only a little over 4 percent of the elderly population did so. Estimates of net migration from 1970 to 1980 indicate movement of elderly persons away from the Middle Atlantic States and the East North Central States (e.g., New York, Illinois, Michigan, Ohio) and into retirement areas, rural areas, and small towns in the South and West, especially Florida, Texas, Arizona, California, and Nevada. Of the population 65 and over who lived in the West in 1980, about 7 percent were new residents since 1975, and 6 percent of the elderly in the South were new since 1975 as compared with 2 percent in the Northeast and North Central States who were migrants.

Most movement of the older population from 1975 to 1980 was within the same metropolitan area and usually did not involve a major relocation. For example, those who had lived in the central city tended to move someplace else within the central city, while those who had lived in the suburbs tended to move someplace else within the suburban area. Only about one-half of 1 percent of elderly movers moved from a suburban area to the central city. From 1975 to 1980, a net average of 45,000 elderly persons moved to rural areas and small towns in nonmetropolitan areas each year. Persons aged 55 to 74 years old were almost three times as likely to move from a metropolitan to a nonmetropolitan area as the reverse, but for persons 75 and over, migration streams in each direction were equally likely. A variety of factors--medical care, decreased physical mobility, widowhood, and the wish to be near family--may explain this shift for those over 75. About 5 percent of the total older population moved from one nonmetropolitan county to another.

Of those who are 65 years and over, unmarried persons are more likely to move than are married persons, those in the labor force are less likely to move than those not working, the better educated are more likely to move, and the majority of elderly families receiving assistance income tend not to move. Further, many older persons who move to nonmetropolitan areas are motivated by positive images of rural or small town life or negative views of metropolitan life. Most have preexisting ties to the new area, such as family, friends, or property.[33]

[33] Ibid.

TABLE 9.
Number and Percentage of Each State's Total Population Aged 65 and Over: 1980
(April 1, 1980, census count. Numbers in thousands)

State	All ages		65 and over				Percent increase 1970-80
	Number	Rank	Number	Rank	Percent	Rank	
Alabama	3,890	22	440	19	11.3	24	35.8
Alaska	400	51	12	51	2.9	51	71.4
Arizona	2,718	29	307	28	11.3	25	90.7
Arkansas	2,286	33	312	27	13.7	2	31.6
California	23,668	1	2,415	1	10.2	34	34.9
Colorado	2,889	28	247	33	8.6	46	32.1
Connecticut	3,108	25	365	26	11.7	18	26.7
Delaware	595	48	59	48	10.0	36	34.1
District of Columbia	638	47	74	46	11.[illegible]	20	5.7
Florida	9,740	7	1,685	3	17.3	1	71.1
Georgia	5,464	13	517	16	9.5	41	41.6
Hawaii	965	39	76	45	7.9	49	72.7
Idaho	944	41	94	41	9.9	37	40.3
Illinois	11,418	5	1,261	6	11.0	29	15.8
Indiana	5,490	12	585	13	10.7	31	18.9
Iowa	2,913	27	387	24	13.3	4	10.9
Kansas	2,363	32	308	29	13.0	8	15.5
Kentucky	3,661	23	410	21	11.2	27	22.0
Louisiana	4,204	19	404	22	9.6	39	32.5
Maine	1,125	38	141	38	12.5	11	23.7
Maryland	4,216	18	466	23	9.4	42	32.9
Massachusetts	5,737	11	727	10	12.7	10	14.8
Michigan	9,258	8	912	8	9.8	38	21.8
Minnesota	4,077	21	480	18	11.8	17	17.9
Mississippi	2,521	31	289	31	11.5	21	30.8
Missouri	4,917	15	648	11	13.2	5	16.1
Montana	787	44	85	43	10.7	32	25.0
Nebraska	1,570	35	206	35	13.1	7	12.6
Nevada	799	43	66	47	8.2	47	113.0
New Hampshire	921	42	103	40	11.2	28	32.1
New Jersey	7,364	9	860	9	11.7	19	23.9
New Mexico	1,300	37	116	38	8.9	45	65.7
New York	17,557	2	2,161	2	12.3	13	10.8
North Carolina	5,874	10	602	12	10.2	35	46.1
North Dakota	653	46	90	44	12.3	14	21.2
Ohio	10,797	6	1,189	7	10.8	30	17.7
Oklahoma	3,025	26	376	25	12.4	12	25.8
Oregon	2,633	30	303	30	11.5	22	34.1
Pennsylvania	11,867	4	1,531	4	12.9	9	20.8
Rhode Island	947	40	127	37	13.4	3	22.1
South Carolina	3,119	24	287	32	9.2	44	51.1
South Dakota	690	45	91	42	13.2	6	13.8
Tennessee	4,591	17	518	15	11.3	26	35.6
Texas	14,228	3	1,371	5	9.6	40	38.8
Utah	1,461	36	109	39	7.5	50	41.4
Vermont	511	49	58	49	11.4	23	23.4
Virginia	5,346	14	505	17	9.4	43	36.7
Washington	4,130	20	431	20	10.4	33	31.7
West Virginia	1,950	34	238	34	12.2	15	22.7
Wisconsin	4,705	16	584	14	12.0	16	19.7
Wyoming	471	50	38	50	8.0	48	66.7

See notes at source.

Marital Status and Living Arrangements

Patterns of living arrangements and marital status differ sharply between elderly men and women. Five-sixths of the men live in a family setting and more than three out of four are married and living with their wives. Almost three-fifths of the women live in families, but only two-fifths are married and living with their husbands. Elderly women are more likely to be widowed than married, and a substantial proportion live alone. Half of elderly women are widowed, compared with only 1 out of 8 elderly men. Nearly 70 percent of women 75 years and over are widowed, compared with a fifth of aged men (figure 18). These differences are due to both the higher age-specific death rates of adult men and to the fact that men tend to marry younger women. Elderly widowed men have remarriage rates which are about seven times higher than those of women.[34]

[34] U.S. Dept of Commerce, Bureau of the Census, Jacob S. Siegel, *Demographic Aspects of Aging and the Older Population in the United States*, Current Population Reports, Series P-23, No. 59, Washington, U.S. Govt. Print. Off. pp. 46, 47, 1982.

In 1982, 4 percent of elderly men and 6 percent of elderly women had never married, and 3 and 4 percent, respectively, were divorced, an increase since the 1960's.

Elderly White males had the highest probability of being married, elderly Black females the least. Yet, once married, Black females were most likely to be widowed, White males the least. Black persons were much more likely to be either single, separated, or divorced than were White persons.

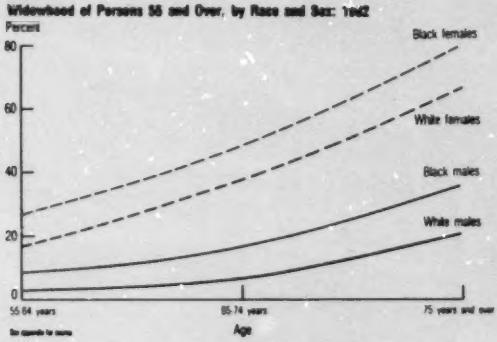
Of the over 7 million elderly persons living alone in 1982 (about 30 percent of the elderly population), most were women. Two-fifths of elderly women lived alone as compared with 1 out of 7 elderly men. Of those 75 years and over, half of the women and about a fifth of the men lived alone.

Educational Attainment

Although educational attainment of the elderly population is well below that of the younger population, the gap in median school years completed has narrowed somewhat over the last 30 years and is expected to nearly close in the next 10 years. Even today, the proportion of the population aged 55 to 64 years which has completed high school is nearly equal that of the younger population (table 10).

In 1982, the percentage of the population 65 years and over which had graduated from high school was about three-fifths as great as in the entire population 25 years and over. About 44 percent of the elderly population were high school graduates as compared with 71 percent of the population 25 years and over. Nearly a third of elderly White Americans and two-thirds of elderly Black Americans never went beyond elementary school. Nearly half of Whites and three-fourths of Blacks over the age of 75 never attended high

FIGURE 19.
Widowhood of Persons 55 and Over, by Race and Sex: 1982



See appendix for source.

TABLE 10.
Years of School Completed by Persons 25 Years and Over, by Age, Race, and Sex: March 1982

	Percent			
	8 years or less	4 years of high school or more	College, 4 or more years	Median school years completed
All races				
Both sexes:				
25 and over	15.7	71.0	17.7	12.8
55 to 59	17.5	66.8	14.3	12.4
60 to 64	23.2	60.8	10.8	12.3
65 to 69	29.2	53.1	10.3	12.1
70 to 74	38.2	44.8	9.8	10.8
75 and over	49.7	36.3	8.0	9.9
Male:				
25 and over	15.7	71.7	21.9	12.8
55 to 59	18.6	64.4	19.7	12.4
60 to 64	24.0	59.9	13.7	12.3
65 to 69	30.9	51.7	13.2	12.1
70 to 74	43.1	43.0	12.0	10.5
75 and over	55.1	33.9	10.3	8.9
Female:				
25 and over	15.8	70.3	14.0	12.5
55 to 59	16.3	67.1	9.5	12.4
60 to 64	22.8	61.5	8.3	12.3
65 to 69	27.8	54.2	8.0	12.1
70 to 74	36.7	46.0	7.9	10.9
75 and over	47.7	38.1	6.7	9.4
White, both sexes:				
25 and over	14.7	72.8	18.5	12.8
55 to 59	14.9	68.1	15.2	12.5
60 to 64	20.9	63.6	11.4	12.3
65 to 69	25.9	56.5	10.8	12.2
70 to 74	35.2	47.8	10.3	11.3
75 and over	47.3	37.2	8.5	9.4
Black, both sexes:				
25 and over	24.8	54.9	6.8	12.2
55 to 59	38.8	36.9	4.9	10.3
60 to 64	46.4	33.2	3.8	9.7
65 to 69	59.0	21.0	4.7	8.4
70 to 74	65.9	18.9	3.0	7.9
75 and over	74.0	15.4	3.4	6.8

See appendix for source.

school. Forty-seven percent of elderly Whites completed high school, while only about 1 in 5 elderly Blacks reached that level.

In terms of higher education, 10 percent of elderly Whites attended 4 or more years of college as compared with about 4 percent of elderly Blacks.

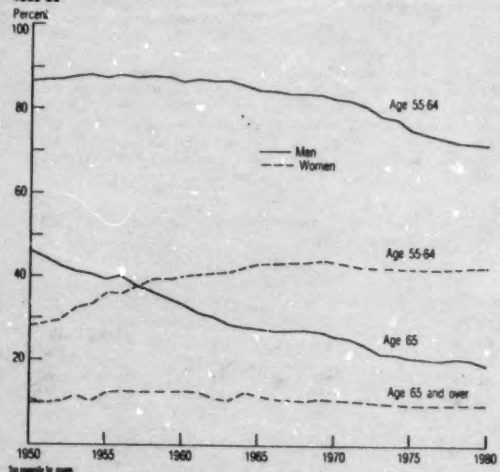
The gap in educational attainment between age groups is expected to narrow significantly over the next 10 years, partly because of the educational opportunities that became available after World War II and partly because of our history of immigration. Today's elderly population has a much higher proportion of foreign born than does the younger population. The elderly foreign born have a higher rate of illiteracy and lower educational attainment than the native population.

Labor Force Participation

The labor force participation of elderly men has dropped rapidly over the last 30 years (figure 19). In 1950, almost half of all elderly men were in the labor force; by 1960, only a third were working or looking for work; by 1970, only a fourth; and by 1981, less than a fifth (18.4 percent or 1.9 million). The decreases are partly due to an increase in voluntary early retirement and a drop in self-employment. The decrease in male labor force participation extends even to men in their fifties. In 1960, over 88 percent of males in the 55- to 59-year-old group were in the labor force; by 1981, it had declined to just over 80 percent. In 1960, 77 percent of men aged 60 to 64 worked, but by 1981, less than 60 percent did. At age 70 and over, in 1960, one out of four men worked, but by 1981, the proportion had dropped to one out of eight.

Labor force participation of elderly women, however, has varied little. In

FIGURE 20.
Labor Force Participation of Persons Aged 55 to 64 and 65 and Over, by Sex: 1950-80



See appendix for notes.

TABLE 11.
Labor Force Participation and Unemployment Rates, by Age and Sex: November 1982
(In thousands)

Labor force participation	55 to 64 years old			65 or more years old		
	Total	Male	Female	Total	Male	Female
Seasonally adjusted:						
Civilian labor force	12,188	7,234	4,935	3,011	1,838	1,174
Labor force participation rate (percent)	55.4	70.7	42.1	11.8	17.6	7.7
Number unemployed	724	470	254	142	97	46
Unemployment rate (percent)	6.0	6.5	5.1	4.7	5.3	3.9
Number employed	11,444	6,763	4,681	2,869	1,741	1,128
Not seasonally adjusted:						
Number employed	11,481	6,777	4,704	2,920	1,767	1,153
Employed part time:						
For economic reasons	662	330	312	181	100	82
As a matter of choice	1,445	345	1,099	1,382	754	628
Employed full time	9,365	6,093	3,292	1,347	913	433
Number unemployed	670	397	273	131	87	44
Duration of unemployment:						
Less than 5 weeks	204	123	80	50	29	21
5 to 14 weeks	138	67	71	21	10	11
15 to 26 weeks	143	87	56	25	23	2
27 or more weeks	186	99	66	26	16	10
Average (mean) duration (in weeks)	20.9	21.6	19.9	15.6	16.9	13.1
Median duration (in weeks)	12.9	13.0	12.8	7.4	8.1	7.1

Note: The U.S. labor force includes workers who are employed or actively seeking employment. The participation rate is the percentage of individuals in a given group (e.g., age group) who are in the labor force.

See appendix for notes.

37-680 O—84——34

1950, about 10 percent of elderly women worked, and by 1981, the percentage had dropped only to 8 percent (1.2 million). For women over the age of 70, labor force participation dropped from 6 percent to just under 5 percent from 1950 to 1981. But women between the ages of 55 and 64 have increasingly joined the work force: in 1950, only 27 percent of these women worked, but by 1982 the proportion had risen to 42 percent. (table 11)

Historically, among older Black women, labor force participation has been distinguished by much higher rates than those for White women. Over the last 30 years, however, the rates have converged so rapidly that, by 1981, only a few percentage points separated the two groups. The extent of labor force participation for older Black males is somewhat lower today than the rate for older White men, and it has fallen more rapidly. (table 12)

TABLE 12.

Labor Force Participation and Unemployment Rates, by Age, Sex, and Race: 1981

(Numbers in thousands—noninstitutional population)

Age (years), sex, and race	Total labor force			Not in labor force
	Number	Percent of total population	Percent of civilian labor force unemployed	
Males:				
16 and over	63,939	77.5	7.4	16,537
55 to 64	7,171	76.9	3.8	2,981
55 to 59	4,405	81.2	3.7	1,019
60 to 64	2,766	58.5	3.8	1,962
65 and over	1,886	18.4	2.9	8,303
65 to 69	1,080	27.8	3.2	2,803
70 and over	786	12.5	2.6	5,495
White:				
16 and over	56,409	78.4	6.5	15,585
55 to 64	5,531	71.5	3.4	2,660
55 to 59	1,305	82.3	3.4	884
60 to 64	2,527	59.1	3.4	1,745
65 and over	1,704	18.5	2.4	7,491
Black and other:				
16 and over	7,530	71.3	14.1	2,952
55 to 64	640	63.3	6.2	372
55 to 59	400	72.0	6.3	155
60 to 64	240	52.6	6.1	217
65 and over	182	16.7	8.0	812
Females:				
16 and over	46,873	52.2	7.9	42,922
55 to 64	4,799	41.4	3.8	6,808
55 to 59	3,003	49.3	4.0	3,091
60 to 64	1,796	32.6	3.6	3,715
65 and over	1,176	8.0	3.6	13,504
65 to 69	724	14.9	4.1	4,145
70 and over	452	4.6	2.8	9,359
White:				
16 and over	40,295	51.9	6.9	37,272
55 to 64	1,235	40.9	3.7	6,111
55 to 59	2,854	49.1	3.9	2,752
60 to 64	1,581	32.0	3.5	3,359
65 and over	1,049	7.9	3.4	12,243
Black and other:				
16 and over:	6,588	53.8	14.3	5,651
55 to 64	565	44.9	4.6	494
55 to 59	349	50.7	4.7	339
60 to 64	216	37.8	4.3	355
65 and over	127	9.1	5.7	1,262

See appendix for notes

Among the 3.1 million elderly workers, over half were in white-collar occupations. Sex and race were important determinants of the occupations of the employed elderly. Three-fifths of elderly White female workers were in white-collar professions and about two-thirds of Black female workers were service workers, predominantly in private households. About one-half of elderly White male workers were in white-collar and one-quarter were in blue-collar work. Over a third of elderly Black males were blue-collar workers with nearly a fourth in white-collar jobs and another quarter in service jobs. Farm occupations were more common among the oldest men: nearly a fifth of Black and a sixth of White working males 70 and over were farmworkers, compared with less than 4 percent for all males 25 years and over.

Part-Time Employment

Part-time work is an increasingly important source of employment for the elderly. In 1981, of the elderly who were at work in nonagricultural industries, 48 percent of the men and 60 percent of the women were on part-time schedules as compared with 30 percent of the men and 43 percent of the women in 1960 (table 12). Most who are on part-time schedules report that it is their choice to work part time rather than being forced to work part time for economic reasons.[35] Over the last decade, elderly men have made up 5 to 6 percent of all persons on voluntary part-time work schedules, and elderly women have made up about 4 percent as compared with women 18 to 64 years old who constitute about 50 to 60 percent of such workers.[36]

[35] U.S. Dept of Labor, Bureau of Labor Statistics, Employment and Earnings for January 1981, 1971, and 1962.

[36] Employment and Training Report of the President, 1981, Table A-26, p. 188.

Unemployment

The unemployment rate for the elderly in 1982 (4.7 percent) was about half that of the population 16 years and over. Unemployment among older workers (55 and over) at the close of 1982 (6 percent) was the highest since the Government began measuring joblessness after World War II. More than 770,000 Americans 55 and over were out of work. This figure increases to 1.1 million if discouraged workers who stopped looking actively for work are included.[37]

Older workers, once they lose their jobs, stay unemployed longer than younger workers, earn less in a subsequent job than younger workers, and are more likely to give up looking for another job following a layoff. Persons 55 and over are out of work on the average nearly 20 weeks before being reemployed. That is 23 percent longer than the 15.5 weeks between jobs, on the average, for all unemployed Americans. Likewise, the older worker who successfully finds another job will, on the average, earn $1,500 less than he or she got earlier.[38] Finally, older workers are more than twice as likely as others to give up searching for a new job. There are about 334,000 discouraged workers 55 years and older who are no longer counted as unemployed because they've stopped looking for work.[39]

[37] U.S. Dept. of Labor, Bureau of Labor Statistics, unpublished data, November 1982.

Housing

Housing, while an asset for most older people, represents a serious problem for others. In 1979, 3 out of 4 of the households maintained by an elderly person were owner occupied; nearly half were owned free and clear. Two-thirds of all homes owned free and clear are maintained by an elderly person.

[38] Mincer, J., and H. Ofek. "Interrupted Work Careers: Depreciation and Restoration of Human Capital," *Journal of Human Resources*, vol. 17, Winter 1982, pp. 1-24.

[39] U.S. Dept. of Labor, Bureau of Labor Statistics, unpublished data, November 1982.

Homeownership is most often related to intact families, yet over a third (37 percent) of owner-occupied elderly households were inhabited by elderly men and women living alone. Only one-third of renter-occupied elderly households were maintained by elderly persons in families; the other two-thirds were maintained mostly by elderly men and women living alone.

Voting Behavior

There are direct relationships between voter participation rates and the demographic and socioeconomic characteristics of the electorate. In the November 1980 election, one-third (30.7 million) of those who reported voting were 55 years or older. Of all age groups, voters age 55 to 64 had the highest participation rate (71 percent); with the 65- to 74-year-old group the next highest (69 percent). Voting participation is lower among the aged—58 percent of those 75 and over voted. These figures compare favorably to the rate of voter participation (59.2 percent in 1980) for the total population 25 and over.[40]

Overall, among the elderly, White men were the most likely to vote, followed by White women, then Black men and Black women. Among the elderly who were registered to vote but did not, two fifths attributed the cause to illness. About a fifth of all registered voters did not vote because of lack of interest or lack of preference for either candidate, but the elderly mentioned these reasons only about half as often. Higher education levels, employment, white-collar occupations, higher income, homeownership, and duration of residence in the community were all characteristics associated with high voter participation.

[40] U.S. Dept. of Commerce, Bureau of the Census. Current Population Reports, Series P-20, No. 370, *Voting and Registration in the Election of November 1980*. U.S. Govt. Print. Off., Washington, 1982.

TABLE 13.

Persons 45 Years and Over at Work in Nonagricultural Industries on Part-Time Schedules, by Sex and Age: Annual Averages for 1980, 1970, and 1981

(Numbers in thousands)

Sex and age (years)	Number			Percent		
	Total at work	On full-time schedule	On part-time schedule	Total at work	On full-time schedule	On part-time schedule
1981						
Male:						
45 to 64	14,476	13,675	801	100	94.5	5.5
65 and over	1,395	729	666	100	52.3	47.7
Female:						
45 to 64	10,101	7,532	2,569	100	74.6	25.4
65 and over	983	397	586	100	40.4	59.6
1970						
Male:						
45 to 64	14,915	14,302	613	100	95.9	4.1
65 and over	1,536	943	580	100	61.6	38.4
Female:						
45 to 64	9,306	7,151	2,155	100	76.8	23.2
65 and over	921	473	448	100	51.4	48.6
1980						
Male:						
45 to 64	12,815	12,088	727	100	94.3	5.7
65 and over	1,494	1,040	454	100	69.6	30.4
Female:						
45 to 64	7,059	5,499	1,560	100	77.9	22.1
65 and over	784	446	338	100	56.9	43.1

See sources to table

Summary

The older population is growing faster than the rest of the population and will be an increasing proportion of the U.S. population over the next 50 years. But the implications of this fact for American society and government are not clear without greater differentiation of the trends. Older Americans are not now and will never be a homogenous group subject to sweeping generalizations. Improvements in income and longevity, for example, that have taken place over the last two decades have made the earlier years of retirement much better today than in 1960. But the situation is quite different for the very old population. This group has both a lower average income and a much greater need for health services and living assistance than do younger age groups. Similarly, widows living alone and most minority elderly face very different and more difficult situations tuday than do married, White elderly couples.

While America and the rest of the world are today an aging society, the rate of change will be an uneven one. Essentially, we will enjoy a period for the next 30 years when there will be sustained but undramatic growth in the elderly population. But then, in 2010, there will comv a remarkable surge in the numbers of older persons as the post-war baby boom matures. In less than 30 years, an aging society will be upon us, whether we have prepared for it or not. If we anticipate and plan for this momentous social event now, individuals and families can still adjust their own expectations and plan for their futures. The foreseeably great magnitude of these events challenges our capacity to adapt public policy far enough in advance to be successful and sets the overall context for the decisions made today regarding the aged and aging in America.

Appendix.
Sources for Figures and Tables

Figures

Figure 1. U.S. Department of Commerce, Bureau of the Census, Censuses of Population, 1900 to 1980, and Current Population Reports, Series P-25, No. 922, *Projections of the Population of the United States: 1982 to 2050 (Advance Report)*, middle series projections.

Figure 2. U.S. Department of Commerce, Bureau of the Census, Censuses of Population, 1900 to 1980, and Current Population Reports, Series P-25, No. 922, middle series projections.

Figure 3. U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P-25, No. 922.

Figure 4. Social Security Administration, Office of the Actuary, September 1982.

Figure 5. National Center for Health Statistics, Vital Statistics Division, U.S. Department of Commerce, Bureau of the Census, *Historical Statistics of the United States*, 1975, and National Center for Health Statistics, *Monthly Vital Statistics*, Vol. 29, No. 13, September 1981.

Figure 6. U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P-25, Nos. 310, 311, and 922; middle series projections.

Figure 7. U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P-60, No. 134, *Money Income and Poverty Status of Families and Persons in the United States: 1981 (Advance Report)*.

Figure 8. U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P-60, No. 137, *Money Income of Households, Families, and Persons in the United States: 1981*.

Figure 9. U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P-60 for indicated years, 1981 constant dollars computed.

Figure 10. U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P-60, No. 137.

Figure 11. U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P-60, No. 134.

Figure 12. *Income and Resources of the Aged*, Social Security Administration, No. 13-11871, January 1983.

Figure 13. U.S. Department of Commerce, Bureau of the Census, March 1982 Current Population Survey, Unpublished data.

Figure 14. U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P-60, No. 138, *Characteristics of the Population Below the Poverty Level: 1981*.

Figure 15. U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P-60, No. 138.

Figure 16. U.S. Department of Commerce, Bureau of the Census, 1970 and 1980 Censuses of Population, U.S. Summary, *General Population Characteristics*, Vol. 1, Ch. B.

Figure 17. Executive Office of the President, Office of Management and Budget.

Figure 18. U.S. Department of Commerce, Bureau of the Census, 1970 and 1980 Censuses of Population, U.S. Summary, *General Population Characteristics*, Vol. 1, Ch. B.

Figure 19. U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P-20, No. 380, *Marital Status and Living Arrangements, March 1982*.

Figure 20. U.S. Department of Labor, Employment and Training Report of the President, Transmitted to Congress, 1981, table A-3.

Tables

Table 1. U.S. Department of Commerce, Bureau of the Census, Censuses of Population, 1900-1980, and Current Population Reports, Series P-25, No. 922,

Projections of the Population of the United States: 1932 to 2050 (Advance Report), October 1982. Projections are middle series.

Table 2. U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P-25, No. 922.

Table 3. U.S. Department of Commerce, Bureau of the Census, Series P-25, No. 922, Series P-25, No. 311, *Estimates of the Population of the United States, by Single Years of Age, Color, and Sex: 1900 to 1959*, July 1965; and Series P-25, No. 310, June 1965. Projections are middle series.

Table 4. U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P-60 for indicated years. 1981 constant dollars computed.

Table 5. U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P-60, No. 134, *Money Income and Poverty Status of Households Families and Persons in the United States: 1981, (Advance Report)*, and unpublished data.

Table 6. The data for 1963, 1970-74, and 1977 are from the U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, *Nursing Home Residents: Utilization, Health Status, and Care Received*, 1977 Nursing Home Survey. Vital and Health Statistics, Series 13, No. 51, HHS Pub. No. (PHS) 81-1712.

Table 7. U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, Vol. 31, No. 6, Supplement, September 1982, table 5.

Table 8. Prithwis Das Gupta, U.S. Department of Commerce, Bureau of the Census, *Cause of Death Analysis of the 1978 Mortality Data by Age, Sex, and Race*, January 1981, unpublished.

Table 9. U.S. Department of Commerce, Bureau of the Census, 1980 Census of Population, *General Population Characteristics*, PC-80-1-B for each State.

Table 10. Bureau of the Census, Current Population Survey, March 1982, unpublished.

Table 11. U.S. Department of Labor, Bureau of Labor Statistics, Current Population Survey, November 1982, unpublished.

Table 12. U.S. Department of Labor, Bureau of Labor Statistics, *Employment and Earnings*, Vol. 29, No. 3, March 1982.

Table 13. U.S. Department of Labor, Bureau of Labor Statistics, *Employment and Earnings*, January 1982, January 1971, and January 1961.

Current
Population
Reports

SPECIAL STUDIES

Series P-23, No. 128

America in Transition: An Aging Society

FIGURE 1
Population 55 Years and Over, by Age: 1900–2050

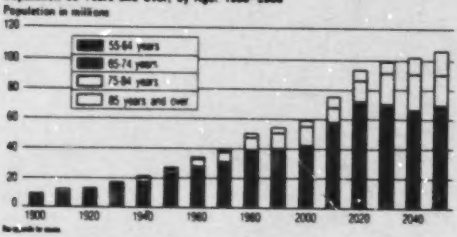
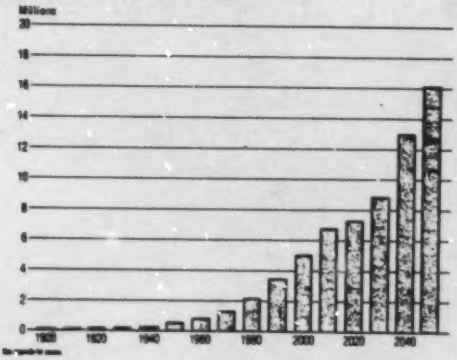


FIGURE 2
Population 85 Years and Over: 1900–2050



ERRATA SHEET

In the published report, the scale caption for figure 1 should have read "Population in millions," and the scale caption for figure 2 should have read "Millions."

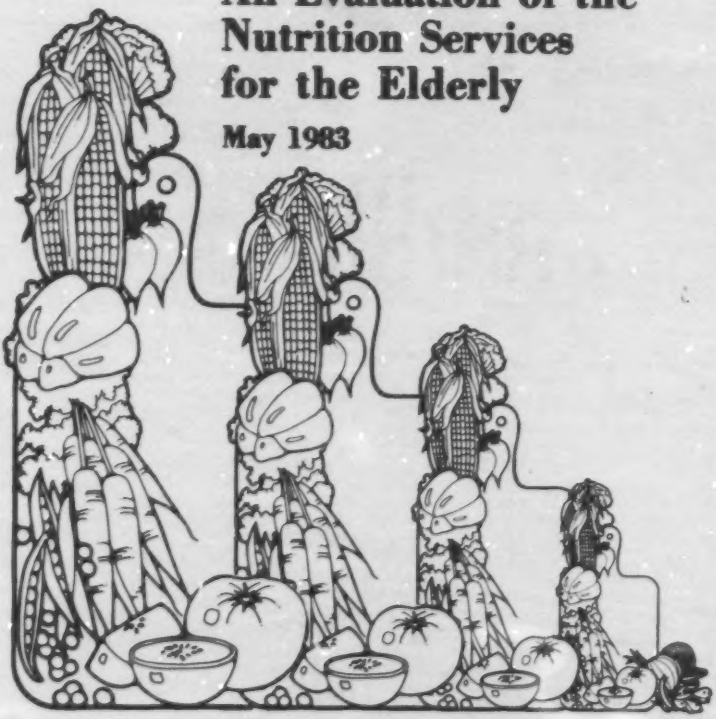
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Human Development Services
Administration on Aging

hds

Volume 1: Executive Summary

An Evaluation of the Nutrition Services for the Elderly

May 1983



Volume I

EXECUTIVE SUMMARY

AN EVALUATION OF THE NUTRITION SERVICES FOR THE ELDERLY

Conducted for

THE ADMINISTRATION ON AGING
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

By

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Contract No. 105-77-3002
DHHS Publication No. (OHDS) 83-20915
(Volume I of a 3 volume set)

The Evaluation of the Nutrition Services for the Elderly is a nationwide study of service operations and elderly citizens participating in services authorized by Title III-C of the Older Americans Act. This evaluation was jointly conducted by Kirschner Associates, Inc. and Opinion Research Corporation. This report is the second of two evaluations, the first of which was conducted during 1976/77.

Nutrition Services were originally authorized by Title VII of the Older Americans Act, but in 1978 their authorization was changed to Title III-C of the Amended Act. Two separate services are authorized by Title III-C: congregate dining and home-delivery.

Title III-C (Subpart 1) authorizes meals served in congregate settings. In addition to providing at least one nutritionally balanced meal, this service may include nutrition education activities and other services deemed appropriate for participants.

Title VII of the Older Americans Act provided that nutritionally balanced meals could be delivered to homes of older persons, but targeted this service to those over 60 years who were "... homebound by reason of illness, incapacitating disability or ... otherwise isolated." In 1978 the Home-Delivered Meal Service was authorized separately under Title III-C (Subpart 2).

The Nutrition Services address a number of problems faced by the nation's older population. Such problems include dietary inadequacy, declining health status, social isolation, and limited access to social and health services. Among certain subpopulations of the elderly -- the poor, ethnic minorities, the isolated, and handicapped -- these problems may be more acute. The Nutrition Services were designed to emphasize services to these groups of priority elderly through outreach efforts to encourage their participation and locating meal sites where they will be accessible to older persons in greatest need.

The major activity of the service is to provide one nutritionally balanced meal per day to the elderly either in a congregate dining setting or through the provision of home-delivered meals. Congregate dining sites and their attached home-delivered meal services are located throughout the country, although all congregate dining sites do not offer home-delivered

meals. Other home-delivery programs, such as Meals on Wheels, often operate in locales where Title III-C home-delivered meals are not offered. Participants are encouraged to contribute to the cost of either their congregate or home-delivered meal.

Besides providing a nutritionally balanced meal, the second major goal of the Nutrition Services is to ameliorate isolation and loneliness that can characterize less mobile elderly citizens; hence, the congregate dining component of the Service which affords opportunities for social interaction and companionship.

In addition to the important dietary and social aspects of the Nutrition Services, nutrition sites are encouraged to provide certain supportive services if needed and not otherwise available to participants. Federal regulations identify these services as recreation, transportation, escort services, nutrition education, shopping assistance, counseling, and information and referral to outside agencies.

The principal purposes of the evaluation include descriptive analyses of Services' characteristics and operations as well as of the characteristics of participants. Evaluative components of the research investigated impacts on participants and the Services' characteristics and operations influencing those impacts.

This evaluation was not designed as a management study. Rather, it addresses one basic question: Do the Nutrition Services significantly benefit older Americans?

Findings Regarding the Service Population

The participant population is stable; most intend to remain enrolled, and the service population is aging.

- Two-thirds of those who were participants 6 years ago and were reinterviewed in 1982 have remained enrolled.

- 9 out of 10 participants intend to continue to remain active in the Nutrition Services.

- 6 years ago, one-third of participants were 75 years or older. In 1982, 41 percent of congregate participants and two-thirds of home-delivered meal recipients were this old.

Older persons participate frequently in the Nutrition Services.

- 61 percent of congregate participants attend meal sites 3 or more times each week.

- 82 percent of home-delivered meal recipients receive a meal in their homes 5 times each week.

Although the program does not exclusively serve priority elderly, three-quarters of congregate participants may be considerad priority participants by virtue of advanced age, low income, minority status, isolation, mobility impairment, or the limited ability to speak English. Participants tend to be worse off than non-participants.

- The average age of congregate participants is 73 years.

- Congregate participants are more likely to be single (66%) and live alone (55%) than non-participants living in the same locales.

- Over one-half of participants had low incomes (52% below $6,000; 75% below $10,000); less than one-half of non-participants had incomes below $6,000 in 1981.

Home-delivered meals constitute approximately 22 percent of all Nutrition Services meals and serve an especially needy group.

- Home-delivered meal recipients are older (average age = 78 years), poorer (65% below $6,000 1981 income), and are in poorer health than congregate participants.

Findings Regarding Program Characteristics and Operations

Recruitment is less extensive than in the past and less emphasis is placed upon enrolling priority elderly persons. Most congregate sites are operating at or near capacity.

Transportation is available to participants at most sites, but most participants get to and from meal sites without site assistance. They have little difficulty getting to congregate sites.

- Transportation is available for participants at more than 8 of 10 sites.
- One-fifth of congregate participants use site assistance to get to their sites.
- Nearly 9 of 10 participants report "no difficulty" getting to sites.

Volunteers, most of whom are participants, play an important role in the Nutrition Services.

- Typically, a meal site has one paid staff person and the remainder of staff are volunteers.
- 90 percent of volunteers are participants.
- 20 percent of participants perform volunteer work for The Nutrition Services.

A majority of providers (organizations that administer meal sites) prepare meals in central kitchens or at meal sites. This represents a substantial change, in that, six years ago,a majority of providers served meals prepared by contractors or caterers.

Record keeping (e.g. participant rolls, cost records, amount of support services provided) has improved over the past few years, but room for improvement remains.

There is extensive organizational layering in the Nutrition Services. Among the several management layers there is some confusion regarding outreach emphasis and contributions policies.

Contributions practices vary widely and appear to be sensitively applied. Although receipts from contributions (average = 57¢ and 62¢ for congregate and home-delivery respectively) generally meet staff expectations, they do not approach costs (approximately $4.09 to provide a congregate meal; approximately $4.70 to provide a home-delivered meal).

Findings Regarding Nutrition Services' Impacts

The Services do achieve a principal goal of enhancing dietary intake. Increased nutrient intake is directly related to participation in the congregate and home-delivery services.

Calcium intake, in particular, is substantially increased by participation. This finding is of significance, as low calcium intake by older persons may contribute to medical problems (i.e. osteoporosis). The Nutrition Services have an opportunity to even further improve calcium intake among older Americans.

Social benefits of participation are ranked even higher by congregate participants than the meal. Home-delivered meal recipients also highly value the social contact afforded by meal delivery persons.

Participants who utilize support services (e.g. shopping assistance, medical assistance and referral) are those who tend to most need them.

- Those who utilize shopping assistance are more isolated in that they tend to live alone, report having too few friends, and are rarely visited by their children.

- Those who utilize site medical assistance lead more isolated lifestyles and are less educated.

Nutrition education activities offered by meal sites have no discernible impact upon participants' dietary intakes away from the site.

Variations in program characteristics and operations do not substantially influence service impacts upon participants.

* * * * * * * *

The Evaluation of the Nutrition Services for the Elderly was conducted in two waves. Wave I took place during 1976/77 and Wave II was executed during 1982. The evaluation is best characterized as two nationwide studies separated by approximately six years.

The services expanded considerably from 1976 through 1982. In 1976 approximately 6,700 congregate meal sites were in operation. By 1982, that number more than doubled to approximately 13,500. During this period the average size of meal sites has also increased: from less than 50 meals (congregate plus home-delivered) served per day to about 60 meals served per day. It is estimated that, nationally, approximately 800,000 congregate and home-delivered meals were being served per day in 1982, more than twice the number estimated in 1976.

The 1982 phase of the evaluation was, as in 1976/77, national in scope and consisted of two integrated components. Kirschner Associates, Inc. made observations and conducted 350 staff interviews at a representative sample of 70 meal sites representing 70 service providers in 29 states. All ten DHHS regions were included. Thirty-four of the congregate sites visited during 1982 were also visited during 1976/77. Thirty-six sites were visited for the first time in 1982. Interviews were conducted at several management levels:

- State Nutrition Service Directors (N=29)
- Area Agency on Aging Directors (N=67)
- Nutrition Service (Provider) Directors (N=70)
- Nutrition Provider Nutritionists/Dieticians (N=54)
- Advisory Council Members (N=60)
- Meal Site Managers (N=70)

Opinion Research Corporation conducted 3,438 interviews with participants and non-participants at the same 70 meal sites and their adjacent locales:

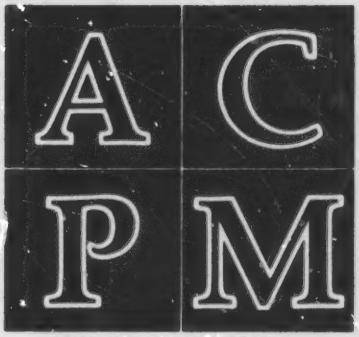
- Congregate Service Participants (N=1,735)
- Home-Delivery Service Participants (N=415)
- Non-Participating Neighbors (N=1,039)
- Former Participants (N=249)

Substantial efforts were made to locate and reinterview as many respondents who had been interviewed at the thirty-four sites visited during 1976/77. Three-quarters of those who were available to be reinterviewed were successfully reinterviewed.

THE FIFTH
KATHARINE BOUCOT STURGIS LECTURESHIP
IN PREVENTIVE MEDICINE

Prevention Policy — Prevention Politics

WILLIAM F. BRIDGERS, M.D.



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American College of Preventive Medicine

Prevention Policy — Prevention Politics

THE FIFTH KATHARINE BOUCOT STURGIS LECTURESHIP IN PREVENTIVE MEDICINE

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Dean, School of Public Health, University of Alabama in Birmingham

I thank the College for inviting me to deliver this annual Sturgis lecture. I am honored to have been selected, taking this as recognition of the efforts being expended by my colleagues in the Association of Schools of Public Health in trying to move the prevention movement along the path we all see so clearly, albeit a path not yet freed of all impediments for a smooth journey. I will mention some of ASPH's initiatives, but this presentation for the most part represents my own views of the state of the nation, vis-à-vis prevention, its policies, and its politics; my colleagues are absolved of all responsibility in this regard.

I do not know Dr. Sturgis. I wish I did. A reprint of Dr. Foege's lecture in 1979 included a brief biography of her career, and after reading it, it is abundantly clear why the American College of Preventive Medicine felt it appropriate to honor her through the establishment of this series.

I do know some of the past lecturers. They have set a high standard not only in the timeliness of their topics but in the intellectual approaches in their presentations. These two criteria, timeliness and some intellectual content, are those a lecturer must meet in order to hold my attention under these adverse conditions: nice reception. Nice dinner. Who needs a lecture?

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I suspect you would subscribe to my criteria, and I shall try to meet them, although the topic I have chosen, Policy and Politics, may strike you at first consideration almost by definition not to hold out much promise for intellectual content.

Certainly, the topic I have chosen meets the other criterion: timeliness. If ever there was a point in the recent history of man when we could legitimately claim that every sign points to a huge payoff from implementation of a prevention policy, it would have to be now. From the Bronze Age, when life expectancy at birth was perhaps age 18, until sometime before 1900 when there had occurred a gradual increase of some 29 years, it would be difficult to find evidence of a widespread prevention revolution. Then, of course, we did enter one that led to another 29-year-or-so jump in life expectancy at birth, this occurring over a period of perhaps the last hundred years, but there still wasn't too much action, vis-à-vis life expectancy increases for adults, until only a few years ago. But the signs and symptoms presently all point toward the likelihood that it's our turn--that we adults, we taxpayers, could see a salutary increase in our life expectancy plus, perhaps of even more importance, an increase in our vitality: a decline or compression of morbidity and the resultant dependency states. And we might even expect to see a decline in our outlays for treatment care if all the needed prevention measures were implemented. I'll return to this hopeful possibility later, because it is a statement that still arouses much skepticism in some.

I do not in any way discount the importance of our preventive efforts already underway in local and state health departments, in some segments of the private sector, and at the federal level including mainly the Public Health Service and its Office of Disease Prevention and Health Promotion, the Centers for Disease Control, and other agencies including the NIH, where brand new programs are underway. Notable in this regard is the new Epidemiology and Oral Disease Prevention Program in the NIDR and the March 6 announcement of a new Cancer Prevention Awareness Media Program at NCI.

With no implication that we as a nation haven't given the matter of prevention policy considerable thought and some action, let's nevertheless pose this question early in the lecture: why don't we have an organized and adequately funded prevention services system? Comparison of all of our prevention initiatives with, say, even our political activities to implement and pay for therapeutics via Medicare, for example, suggests we've hardly left the starting gate with the politics of prevention.

The short answer to my question, why don't we have a prevention services system as a companion to, or perhaps preferably integrated into, our treatment services system, is: because it's not yet our policy. At first mulling, that sounds like a nonanswer, but that's only if you discount the power of this abstract concept we call policy.

Let me explain by giving an example. A friend and I were talking with an official of a large supermarket chain and asked him why one of his stores, which happened to be in our neighborhood, had prices so much higher than those in his other stores. He said, with no hesitation, "Because that's our high profit store." You don't have to be an economist, which I am not, to know that this behavior represents a market failure. And I mean the economic market not the supermarket, which was doing fine. He had determined that his policy would be to overcharge at that store.

Policies can be powerful if they're implemented. The store didn't have to overcharge at that location, but its policy, largely based upon expediency—that is, they had discovered they could get away with it—was to do just that. Indeed, one of the chief attributes of a policy is that it must be believed to be expedient. So one of the subanswers to our question of why we don't have a prevention services system is that we have not proved, at least as yet, that it would be expedient to do so. Expedient, according to Webster, also means useful.

But if the signs are so promising in terms of the potential payoff from a prevention services system, why doesn't it just happen? Perhaps it just might, over time, but I think we could nudge the process along a bit, and indeed I think it may be essential that we do so. As Paul Starr said in the opening line of his landmark book, "The Social Transformation of American Medicine," (Basic Books, Inc., New York, 1982): "The dream of reason did not take power into account." He was using it in a different context, but it is a marvelous statement that answers my question. Every now and then I read something that makes me think, I wish I had written that. One such is that opening line which I will paraphrase: "The appeal to reason must take political power into account." My theme is that that is what we must try to do: The power of politics needs to be, and can be, harnessed for prevention.

But it won't be easy. As Professor Starr points out in his last chapter, we may be entering a new phase in medical care: Instead of continued rapid expansion, especially in yearly expenditures, we may now or soon will be playing in a zero-sum game. Resources needed for preventive initiatives may not be able to come from new sources but may, in effect, have to be diverted from other segments of the system. Personally, I hope Starr's right about the new era being a zero-sum one. It would seem that, with about 11 percent of the GNP at one's disposal, one should be able to cover any and all the bases in health care. Besides, zero-sum gaming adds a little spice to the challenge we face: one of the major prevention funding proposals that we've been working on for a couple of years makes it very explicit that its source of support will be from therapeutic care providers' funds. Doctors and hospitals will be given an opportunity to help finance a prevention services system. I'll describe it a little later.

We would all agree that the nation has a highly visible treatment care system. Whereas we could and do debate the issue of what is, or whether there ever will be, a national health policy that should guide this massive system, we as a nation make fairly clear our willingness to support it when each year we ante up that 10 to 11 percent of our GNP.

I believe it is useful to rephrase the question I posed earlier: Do we have a national prevention policy as a subset or component of our national health policy? The answer must be couched in caveats. It depends to some considerable extent upon what you're trying to prevent and thus how you define the goal of prevention. Some wish to prevent disease and see this alone as a valid defense. Some wish to prevent, through preventive strategies, the escalation in utilization of treatment services.

The answer is also dependent upon what you mean by a policy and, more importantly, what you expect from it: rhetoric or action. Is a policy merely a plan, or is a policy really a policy only when it becomes translated into programs? Another of the attributes of a policy is that in addition to being expedient it is often not explicit. One must infer it from the actions or behaviors of those in charge and those affected. For example, it is the nation's policy to spend some 96 percent of its health care dollars on treatment and only a very small percentage on prevention. You won't find that written in a law, but it is very clear that that's our policy.

Because policy rarely strays too far from the prevailing political wisdom, when all is said and at last something is done, the political route is generally how national policy is implemented. Thus, we can't get very far into a discussion of prevention policy without discussing the politics of prevention, even though we might prefer that prevention could be considered apolitical: a public good or right; an inherent, self-evident value to society. But that's not the reality of the situation. As an analyst of the nation's health care system's policies, and as an active participant in trying to help shape them, I am convinced that if we are to advance beyond the aspirations of a prevention policy or plan toward its implementation, there is no way there other than via the political route. Hence, by way of perhaps too lengthy an opening statement, I have tried to convey to you some insight into what I mean by the title of this lecture: Prevention Policy — Prevention Politics.

In these introductory remarks, I'm sure that a strong inference came through: I suspect we as a nation are still a little uncertain—perhaps vague is a better word—about whether there is bottom-line merit in prevention. The question is not whether it's better in theory for society to prevent a disease than to treat it, but whether there is a proven strategy that can bring that about, and—here's the other bottom line—will it reduce health care costs?

Your first impression is probably a rejection of these somewhat cynical implications on the merits of prevention, on the necessity for tradeoffs, and on the need to sell prevention on the basis of crass concerns such as costs. You will at first reflexly think that everyone surely accepts Ben Franklin's old adage, expressed in the language of the 1980s, that prevention is cost-effective. Well, not quite everyone. Private third-party payers of treatment care are still reluctant to reimburse for most preventive interventions. Why? If you ask them, as I have, they will tell you it is because they fear their costs will go up, not down. They also are uncertain which interventions are valid and therefore worth paying for and which are only passing fads.

It is one of the great ironies in our present health care policy that innovations in the preventive management of a threatened disease (that is, interventions that are aimed at a reduction in incidence rates) are scrutinized ever so much more critically than are innovations in treatment of a disease (that is, interventions that, even if successful, can lower prevalence but which by definition cannot lower incidence rates). Bill Foege has written in the past about this irony.

Others who apparently aren't yet convinced that prevention can save money would include the Health Care Financing Administration. Surely if we had made our case and successfully defended it, HCFA, which is searching for strategies to reduce the costs of Medicare, would have bought it. But they haven't, yet. Medicare will pay for the questionable procedure of radical mastectomy but it will not pay for a mammography screening procedure. Medicare will pay for treatment, such as it is, of lung cancer but not for smoking cessation programs. Indeed, Medicare presently reimburses for only one preventive measure: pneumococcal vaccine. I think it's time for that situation to change. It's under study in the DHHS, and perhaps it will. Please don't misunderstand: This situation is not a criticism of HCFA, but of us. We're not quite finished with the task of selling prevention.

Since I've mentioned Medicare, let me point out another irony within our present system and policy. The annual increase in Medicare outlays now exceeds the total budgets of the NIH, plus CDC, plus Michael McGinnis' operation, plus Prevention Block Grants, plus, I am certain, virtually all other federal initiatives relevant to prevention. Is this reality a reflection of national policy? Apparently. Political wisdom? If so, it's the penny wise, pound foolish variety.

Let us imagine that, for fiscal year '85, the Secretary of the Department of Health and Human Services has decided she would disperse her funds in hourly doles representing an hour's worth of her total expenditures for the year. The money is to be handed out personally to agency heads in her office. Let us suppose that the Director of CDC, being a hustler, managed to be first in line to receive his allocations and that he was given his first check at the stroke of midnight at the start of the fiscal year on Monday, October 1. Each hour on the hour, the Secretary would hand over another warrant

representing another hour's worth of DHHS spending. Dr. Mason would have received his entire appropriation for the year in time to catch a flight back to Atlanta, eat lunch on the plane, and be in his office the afternoon of the first of October. Had the Director of NIH managed to get in line first, Dr. Mason would have had to wait until late Friday night before he received even his first check. Had the head of HCFA managed to get in line ahead of him, Dr. Mason might have made it back to Atlanta in time to do a little hasty Christmas shopping.

How do we go about changing the situation so that the Director of CDC would have to spend at least a couple of days in the Secretary's office receiving his checks? (Reference here is, of course, to funding for prevention, not specifically to CDC.) One approach would be to ask if there are impediments to the achievement of this goal and then try to remove these road blocks. I think one of the major impediments, in this zero-sum game, is the contrast between the here-and-nowness of treatment and the there-and thenness of prevention. Treatment has a positive, action-oriented connotation. Prevention is somehow negative and abstract sounding.

If you claim you can prevent something from happening at some point in the future, and then the future arrives and sure enough, people don't get whatever it was you claimed you could prevent, how do they or even you know for sure they would have gotten it even if you hadn't prevented it? Policy makers believe they're buying something tangible when they purchase therapies—a surgical procedure, a lab test or x-ray, an episode of hospital care—but they're buying nonevents when they purchase prevention, or so they might think. You and I know they're buying life—a positive purchase if ever there was one, yet we're trying to sell a negative: postponement of death; avoidance of disease.

Perhaps we should turn our pitch around. I wonder if there wouldn't be some merit in emphasizing data on infant survival instead of infant mortality. I wonder if CDC, which is to be applauded for its new and very important measure of Years of Life Lost shouldn't consider changing it to Years of Life Gained. Should we start reporting Vitality or Survival rates instead of, or in addition to, Mortality rates? Should the Centers for Disease Control change its name to, perhaps, the Centers for Assurance of Vitality? How about, simply, the Centers of Health? Could we live with the confusion that might arise if we had both the National Institutes of Health and the Centers for Health? Might be confusing to some, but we might indeed live better, perhaps even longer, if these what's-in-a-name suggestions would enhance the visibility—and that means increasing the funding—of the prevention movement.

Before I leave this topic, let me comment a little further on the potential value of a positive mind-set in our approach. If you're planning on having a heart attack, I recommend with enthusiasm that you read Norman Cousins'

new book, "The Healing Heart—Antidotes to Panic and Helplessness," (W.W. Norton and Company, New York, 1983). If his claims are correct, and he seems to have the support of many prominent physicians, Cousins has one-upped us: Although he refers to his efforts to reverse the damage of a massive heart attack as healing, that is, treating, his strategies are really nothing more than traditional and modern preventive approaches (exercise, diet, etc.) with a heavy overlay of positive emotions. He may have an important message about some new turf for prevention: actual reversal, not just stabilization, of serious, life-threatening disease processes. The prevention movement could profit greatly right about now from the writings of someone like Mr. Cousins—someone who would celebrate the likelihood of employing preventive strategies as a way to enhance our chances for happy, joyful lives. Or perhaps it's the reverse: happy, joyful living may be the preventive strategy.

Now let me focus for a few minutes on another, perhaps even more significant, impediment. The idea of Prevention, while rhetorically appealing and historically compelling, still lacks a theoretical base. One of the reasons is that it is not driven by a single method and certainly not by a single discipline as are all traditional academic and most clinical specialties. Rather, it is driven by a goal. This presents a fundamental conflict with the usual view of science as being value-free, although few scientists deep in their heart of hearts really believe that.

Having tried very hard to teach lay people, and specifically lawmakers and their staffs, about prevention, I am now convinced that the task would be ever so much easier if we could somehow lean on a theoretical base, a set of ground rules as a point of reference or departure, regardless of the specific type of prevention or disease that might be under discussion.

A close colleague, George Pickett, President-elect of the College, my favorite associate dean and the one person who has taught me the most about prevention, and I are struggling with this problem. He and I believe one takeoff point toward defining this base could be development of the fact that treatment of disease as an intervention strategy includes implicit acceptance of some amount of dependency. The dependency may be trivial, such as that accompanying a cold, or it could be severe, such as that associated with almost all the major, chronic diseases. But it is virtually an inevitable accompaniment of treatment, if that is the strategy employed in controlling a disease. Prevention, in striking contrast, prevents not only the disease but usually avoids or greatly reduces dependency.

Thus, the true and total costs of treatment interventions within a given community for a given disease are comprised of the costs of diagnosing and treating each case plus the costs associated with the dependency for each case times the probability of a member of that community developing the

disease. The cost of prevention of that disease, assuming there are strategies that will accomplish this, is, simply, the cost of the preventive intervention times the number of people in the community or of some subset, some population at risk.

If you write these statements as simple algebraic equations, rearrange the terms, and combine the two equations, you can surmise, not surprisingly I suppose, once you think along these lines, that the two major determinants of total costs are probably not the comparative costs of treatment of a case versus the cost of prevention of that same case, but they are the incidence rates and the dependency costs. As a general rule, when incidence rates are high and/or dependency costs are high, prevention pays. If P represents prevention costs, and T represents treatment costs, and D is dependency costs, and q is incidence rate, the cost of prevention will be less than treatment whenever P is less than the sum of T + D times q.

Of course, there are many other considerations, such as discounted current costs for events avoided in the future or for events postponed, but the general notion shows promise, at first blush, of giving us a framework on which to hang our defense of prevention as being "worth" it.

Needless to say, an enormous amount of work remains to be done. But if and when it is, I think we'll have a horse we can ride. We'll also have a better handle on when prevention is not worth it. Mass chest x-ray screening programs are a classic example of a preventive intervention not worth it. Presently out of favor are the once popular multiphasic screening programs and annual physical exams. I am sure there will be numerous new innovations—some useful, some not.

We don't require the sort of method I've tried to describe in order to defend the value of some interventions, such as immunization programs. (Or do we? The swine flu saga comes to mind.) We do sorely need it or something similar for many of the proposed behavioral interventions for heart disease risk factors, for some of the chemical interventions for heart disease risk factors presently touted, perhaps for some cancers, and for a host of other conditions.

It is obvious I'm focusing heavily on the cost aspects of the prevention movement. I do not mean to imply that I'm not interested in the more important matter of avoidance of disease. I fervently believe it's better not to have a disease than to have one, regardless of associated costs. But the subject here is policies and politics—how we can gain the needed resources to advance the prevention movement beyond the implementation plan stage to the full implementation stage—thus, my preoccupation, as will be understood by any of you who have ever spent any time on Capitol Hill or on Pennsylvania Avenue, and I don't refer only to the White House but to around the corner at the Office of Management and Budget.

This is an especially critical time when there is underway a pervasive mind-set towards reducing the role of government, not to mention reducing the federal deficit. This is not the best of times to try to sell new programs if they are perceived to add to costs. On the other hand, one has to be pretty certain of what one is talking about if one expects to sell a new program and claim it will reduce costs. Skepticism and raised eyebrows are still the normative responses when you approach even very knowledgeable health staffers and bureaucrats with, "Have I got a deal for you!" Fortunately, we're not trying to sell used cars, but selling is what we're doing, nevertheless.

Let me note only one other impediment, continuing with the cost theme. One often hears, and it is presented as though it is established conventional wisdom, that to the extent that prevention in young people and in middle age does work, it will simply add to the pool of chronically ill and dependent elderly people. In effect, those holding this view believe that sooner or later the piper must be paid, that sooner or later the end result of prevention is that it will add to the total costs of health care.

It just doesn't have the ring of reasonableness. Following the logic of the proponents of this view to its extreme, it is obvious that if people would be considerate enough to die on the way home from their retirement parties on the day they turned 65, we could sharply reduce the outlays for Medicare. We must reject such ludicrous thoughts and work very hard to show that it is indeed "worth" it to live a longer and healthier life.

I have tried to find the studies upon which such negative perceptions could have been based, but the search has been unsuccessful. I suggest that we summarily reject this pessimistic view on the sound grounds that it is not a useful or productive line of thought; at the very least, it flies in the face of a trend toward increased longevity already underway, a trend that we dare not try to stop and fortunately could not. It also fails to take into account some new concepts about aging and the associated burden of morbidity and mortality.

I am certain that you were as astounded as I was to learn in the January 20, 1984, issue of MMWR that premature mortality when expressed as Years of Potential Life Lost from the first birthday to age 65 for persons who died in 1982 decreased an incredible 4.6 percent. It follows that years of life gained for those over 65 increased. Good news or bad news? The answer is obvious. Because to a great extent we're made morbid by the same conditions that lead to mortality, it may also follow that we'll soon see a drop in morbidity as well. I'll return to this point in a moment.

We are only too aware that Medicare costs are escalating at unacceptable rates. But studies by the Congressional Budget Office show that about 90 percent of the increases are due to rising prices and other potentially con-

trollable factors, and only about 10 percent of the increases are attributable to an increase in the number of Medicare beneficiaries.

Most importantly, we are beginning to understand quite a lot more about these beneficiaries. They consist of distinctly different populations. There are survivors and there are succumbers. Females are the classic example of a population of survivors. No doubt there are many other ways to classify the elderly population into these two subgroups.

Studies from HCFA show that decedent Medicare beneficiaries use more Medicare-reimbursed services during their last year of life than do those beneficiaries of the same age who continue to survive. That, of course, comes as no surprise. What is most interesting is that per capita expenditures for decedent beneficiaries decline with advancing age, and they decline quite a lot. The explanation for these findings is not yet available. Perhaps, and I strongly suspect this is part of the reason, measures to prolong life for the 85 year old are less intensive than for the 67 year old.

Whatever the explanation, the Medicare population in any given year consists of a small number of high cost beneficiaries (succumbers) and a very much larger number of lower cost beneficiaries, the survivors. It follows that if prevention programs were to be successful in forcing a continuation in the decline in mortality rates for the elderly, there would be a reduction in high cost beneficiaries, that is, in succumbers, and hence in outlays for their terminal episodes. And don't forget: It costs Medicare less the older you are when you die.

These, of course, are very happy findings for those of us trying to sell prevention as a strategy to reduce Medicare outlays. You hear a lot about experiments designed to reduce prices of episodes of care—the DRG is the latest such—but you hear practically nothing about strategies that would reduce Medicare outlays by reducing the burden of illness and hence the need for the care. Pushing that concept is what we need to be doing. New insights such as those I've just mentioned may very well give us the ammunition we've needed.

My good friend, George Pickett, who understands how to construct life tables and to do nifty things using his home computer, has some admittedly preliminary but very satisfying findings that suggest that for each successive decrement in mortality rates, the Medicare expenditures increase at a much lower rate. Add the valid assumption that those yearly savings are just that: savings that earn interest, and it may be possible some day to defend unequivocally the statement that it's cheaper to prevent than not to prevent. If he and I could find time for more creative thinking and less reacting—that is, deaning—(and if you infer that the two are mutually exclusive, you're essentially correct), we believe we'd soon have some fascinating new information.

I cannot conclude this line of discussion without also noting our gratitude to Dr. Jim Fries, whose compelling and articulate writings in the *New*

England Journal of Medicine and elsewhere have stimulated much thinking about the likelihood that life expectancy may increase but not life span, about the rectangularization of mortality, and most importantly, about the compression of morbidity. It is joyful to anticipate the possibility that some day some diseases' clinically symptomatic states may be postponed (i.e. prevented) to such a late point that you will die first, of other "natural causes." Time won't permit me to go into his arguments here, or those of his critics, but if you haven't been following his work I think you should. You'll find it very stimulating and of seminal importance in our pursuits.

Now let me turn to a listing of some of the politicking activities of the Association of Schools of Public Health. I can't do this without first acknowledging our admiration and great respect for our Executive Director, our leader, Michael Gemmell. I noted that George Pickett teaches me about prevention. Mike is my political mentor, and there's none better. There's also no one doing what he does so well or who is any more dedicated to the prevention movement. It is a delight to try to help him help us all and to follow him around on the Hill and elsewhere in his town.

Time won't permit a recounting of the stories behind each of our initiatives—how we were fortunate enough to have them introduced, how we're keeping some of them alive from one session of the Congress to the next, and the frankly very hard work that has gone into them, not to mention the expenditures of some money and lots of psychic energies. Time will permit only a listing or cataloging.

(1) Schools of public health have managed to hang onto authorization and appropriations for institutional support (capitation) and student stipend support when all other health professional schools were losing theirs. We've also lent our assistance in finding new support for preventive medicine residencies as part of the health manpower legislation. We are optimistic this will all be reauthorized in this session of Congress. Not all of our activities are so overtly self-serving as these, but if the nation is to enjoy the fruits of prevention there has to be support for the training of preventionists.

(2) We have consummated an important new working relationship with CDC that shows great promise to benefit us and them. That was easy.

(3) Not so easy have been our efforts to increase the level of prevention research efforts of the NIH. We have written and testified on the need for a new institute, a national institute for health preservation or some comparable title. We have testified in favor of assistant directors for prevention within the separate institutes. These efforts have not received unqualified support from all parties involved. But we believe we're doing the right thing to pursue them, popular or not.

Out of these activities, a general discomfort emerged rather early that there was no universal agreement on just what is prevention research and what is not. I believe we can take some credit for having raised this question and for trying to contribute to the answer. I am pleased that Mike McGinnis has taken on the task of trying to come up with a definition that the NIH and others can agree on, and according to the draft statement that I saw a few weeks ago real progress is underway.

(4) The activity perhaps most widely known is our proposal that there be established a nationwide network of Centers for Research and Demonstration on Health Promotion and Disease Prevention. It is the sense of the Congress that this idea has merit: The full House and Senate have both let it be known they are in favor, albeit with two separate bills. We expect resolution of this matter any day. This will be one of the very few new initiatives pushed through the present administration, and we are very pleased that we in ASPH played a role in it. I must note our indebtedness to Representatives Shelby, Waxman, Dingell, and others in the House and to Senators Hatch and Kennedy—and the staff members of all of them. For those interested in additional details about the proposal, the latest issue of the *Journal of Public Health Policy* contains a guest editorial on this.

(5) A very recent effort that we have been supporting, largely through testimony before the House Education and Labor Subcommittee on Human Resources, is a new bill introduced by Representative Ike Andrews. The bill would amend the Older Americans Act of 1965, with a new title that would provide the necessary resources and leadership to design a program of health education for older Americans, mainly by taking advantage of the 3,300 existing multipurpose senior centers throughout the nation. As you might have guessed, schools of public health would take the lead role in design, implementation, and evaluation of this needed program, when it is enacted. A similar provision was recently marked up by the appropriate Senate committee; final passage seems highly likely in this session of the Congress.

(6) Mention of the elderly affords me an opening to introduce to most of you for the first time a major new proposal of the ASPH: that Medicare legislation be amended to include a new provision, the Federal Trust for Prevention Education and Practice. We believe that it is time to add to the strategies for reducing Medicare outlays those we espouse: preventive interventions. There would be a tooling-up phase for the program, that is: an increase in the prevention manpower pool; the development of a rational financing mechanism to reimburse for prevention services; testing of model prevention service dispensing centers in both public and private settings;

documentation of the benefits and costs. This phase would be financed indirectly by the therapeutic sector through a voluntary foregoing of a fraction of a percent of the federal reimbursements to them for services rendered to Medicare beneficiaries. The program would not increase federal outlays. Instead, we believe that over time, it would reduce them as the impact of prevention services negated some of the need for the more expensive therapeutic services.

We have not yet presented this proposal in any formal way to our policymakers, but after about two years of test-marketing the concept and refining it, we are ready to proceed when we see a good opportunity to do so. The marshaling of this idea through the Congress promises to be very exciting. I look forward to it.

(7) One last ASPH effort deserves noting here, and tonight is the first announcement of it. With encouragement from several groups and individuals, at our recent meeting in Charleston, we decided to organize the National Committee for Prevention, comprised of organizations interested in enhancing the visibility and funding levels of federally fostered prevention programs. We view the lack of such an entity as a missing ingredient. We are pleased to take the lead in this venture and are anxious to be ready for united action during the FY '86 federal funding cycle.

I shall close now by asking you to recall a few of the fundamentals of biochemistry, a field of hard science I worked in for quite a few years before I became fascinated with health policy, a field some classify as soft art, as contrasted with hard science. The chemistry of life processes is dependent upon enzymes as catalysts. Without them, in theory, the chemical reactions could occur, but not at rates compatible with life. In the politics of prevention—in the conversion of our prevention plans into prevention programs—it would seem that some catalysis might be useful at this time. I invite all of you to become potential enzymes, to jump into the primordial prevention political soup with me. Let's turn up the burner under the prevention pot and see what we can catalyze. A vibrant life for prevention may emerge.

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The American College of Preventive Medicine is a distinguished professional society of physicians engaged in practice, teaching, and research in preventive medicine. Specialty areas are General Preventive Medicine, Public Health, Occupational Medicine, and Aerospace Medicine.

College publications include a Preventive Medicine Newsletter and a Directory of Preventive Medicine Residency Programs. ACPM jointly sponsors with other organizations an annual scientific meeting which includes the Katharine Boucot Sturgis Lectureship.

In 1979, the Board of Regents of the American College of Preventive Medicine unanimously agreed to name its annual Lectureship in honor of Katharine Boucot Sturgis, M.D., in recognition of her outstanding contributions in research, teaching, and service in the field of preventive medicine; her courageous and effective fight against disease and disability; and her wisdom and leadership in attaining preventive medicine goals. The Lectureship provides a nationally recognized forum to explore key issues and highlight innovations in health promotion and disease prevention.

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Submitted to the Subcommittee on Human Resources by Katharine Way.

Find out how much you know about your eyes

Everyone knows that reading in dim light for prolonged periods can hurt your eyes, right?

Wrong.

That's just one of the many misconceptions people have about their eyes, according to a medical center ophthalmologist.

"If reading in dim light were harmful to the eyes, literate people prior to the invention of gas and electric light would have gone blind, Abraham Lincoln among them, because they read by candlelight and firelight," said Dr. M. Bruce Shields, associate professor of ophthalmology.

"Poor light can cause eye fatigue, and should be avoided for that reason. But there's no evidence that it is actually harmful."

That is one of 20 common misconceptions about our eyes that Shields covered in a true/false quiz in the "Features for Patients" section of the October issue of the *N.C. Medical Journal*. Here are the others.

TRUE OR FALSE

1) Wearing glasses that are too strong can cause eye damage.

2) Children should be taught not to hold their books too close when reading because it can hurt their eyes.

3) If children sit too close to the television that can also damage their eyes.

4) Older people who have trouble seeing should not use their eyes too much because overuse will wear them out sooner.

5) People with weak eyes should rest them often in order to strengthen them.

6) Children will likely outgrow crossed eyes given time and patience.

7) Children who have trouble learning to read are likely to have an eye coordination problem that can be helped with special exercises.

8) A cataract is actually a film over the eye that can be peeled off surgically.

9) Cataracts have to be "ripe" before surgery can be done.

10) Cataracts can grow back sometimes after cataract surgery.

11) Glaucoma only occurs in people over 40 years of age.

12) Contact lenses are good for correcting nearsightedness so that eventually neither lenses nor glasses will be needed.

13) In rare cases, contact lenses can get lost behind the eye and even get into the brain.

14) If older people can read the newspaper without their glasses it's a sign their eyes are healthy.

15) People who wear glasses should be checked every year to see if a change is needed.

16) Dark glasses should be worn on a bright day since bright sunlight can harm the eyes.

17) Ideally, more people should use an eyewash regularly to clear their eyes.

18) A blue eye should not be used for transplanting into a brown-eyed person.

19) Headaches are usually due to eyestrain.

• • •

All of the above statements are false and here's why.

1) Glasses are simply a crutch and will neither strengthen nor weaken the physical state of our eyes. It's obviously desirable to have spectacles that will give us optimum vision, but we should never fear going blind for lack of proper glasses.

2) Children have a far greater ability to focus on nearby objects than adults do, and they will often develop the habit of holding reading material close to their eyes. It isn't harmful. It's a habit they'll likely outgrow.

3) The same applies to watching television. There's no evidence that sitting close to the tube will damage eyesight.

4) Using your eyes won't affect the strength of your vision, and we should all take advantage of what sight we have.

5) People with low vision may develop visual fatigue more rapidly than those with normal vision, but rest won't actually strengthen eyesight.

6) In rare cases, crossed eyes in an infant may be a sign of a tumor in the eye, which could be fatal unless treated early. More often, failure to correct crossed eyes at an early age will lead to permanent reduction in vision in one eye, because the child doesn't use it, a condition commonly know as "lazy eye."

7) Reading problems among children are usually referred to as dyslexia and are widely believed to be best handled by specialists in learning disorders. But it's important that the child have an eye exam to rule out any possible visual problem.

8) A cataract is a gradual clouding of the lens of the eye and not a film that grows over the front of it.

9) Not all cataracts require surgery, and with newer surgical techniques, the state of the cataract – whether it is "ripe" – is no longer a critical issue.

10) Once a cataract is completely removed, it will never grow back. Some surgical techniques involve leaving the posterior portion of the lens in place, and this may later become cloudy and require further treatment.

11) The fact is that even babies can be born with a form of glaucoma, and glaucoma can occur at any age, although it does become more common as we grow older.

12) Hard contact lenses will cause a temporary molding of the cornea, or front window of the eye, that is some cases will lead to improved vision when the contacts are removed. But the improvement doesn't usually last very long.

13) It is simply not anatomically possible for a contact lens to go behind the eye or into the brain.

14) Some older people find that they are able to read without their glasses, but it usually means they are becoming more nearsighted, an early sign of cataracts.

15) It is rarely necessary to have your glasses checked on an annual basis. Once every several years is usually sufficient.

16) Unless you look directly at the sun, being outside on a bright day won't hurt your eyes.

17) Only under special circumstances do our eyes require eyewash, and it is best to seek the advice of an ophthalmologist before using it regularly.

18) Eye transplantation involves only a portion of the cornea, so the color of the iris makes no difference since it is not involved in the operation.

19) Only rarely are headaches due to eyestrain, but it's a good idea to have your eyes checked as part of a complete evaluation for chronic headaches.

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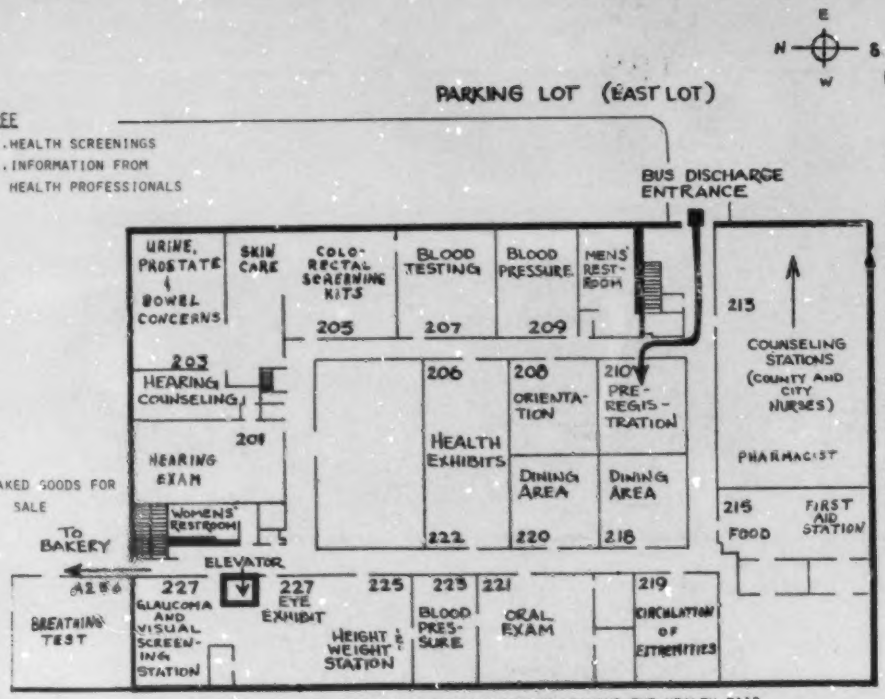

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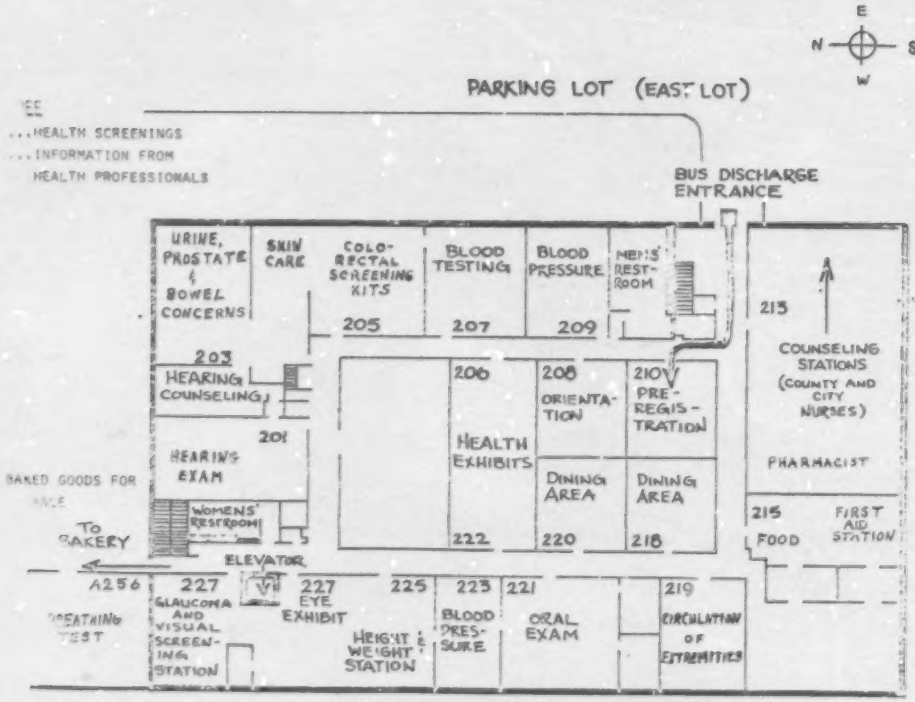

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STOP AT NURSE COUNSELING STATION BEFORE LEAVING THE HEALTH FAIR

AN EVALUATION OF THE SHEBOYGAN COUNTY HEALTH PROMOTION DISEASE PREVENTION MODEL FOR THE ELDERLY

by

Jenifer Brown

University of Wisconsin - Madison

May 1981

> The impetus behind evaluation research can be attributed to the contributions it can make toward improved planning, better management, and greater accountability of social programs. The principles and methods of research are applied to social programs for the purpose of documenting the relative level of effort expended and outcomes achieved. Central to the main purpose of evaluation research is the assessment of the relative extent to which a social program achieves its goals, and demonstration that movement toward program goals actually resulted from the program or activity under study. Because of the political dependency of social programs, decision-makers are utilizing empirical evidence to rationalize the processes of program development, policy-making, budget submissions, and managment.[1]

PART I INTRODUCTION

In 1979, the Sheboygan County Office on Aging implemented a health promotion and disease prevention program as one approach to attain the goals of preventing deterioration, avoiding needless institutionalization, and maintaining functional independence among the elderly population of Sheboygan County. Ilajean Horowitz, Director of the Sheboygan County Office on Aging, identified the general physical, emotional, and social needs of the elderly from a comprehensive review of the literature. In "A Health Promotion Disease

[1] Leonard Rutman, "Formative Research and Program Evaluability", in Evaluation Research Methods, ed., Leonard Rutman, (Beverly Hills, California: Sage Publications, Inc., 1977).

Prevention Model for the Elderly", Horowitz assessed the needs of the Sheboygan County elderly population by analyzing the comprehensiveness, availability, efficiency, and effectiveness of the existing services in Sheboygan County in meeting the physical, emotional, and social needs of the elderly residents.[2] She determined that, although Sheboygan County offered a wide range of services to meet the physical, emotional, and social needs of the target population, inadequacies existed in the service delivery system.

The development of the Wellness Services and Educational Model Program represents the attempt by the Sheboygan County Office on Aging to close the gaps in the existing service delivery system in meeting the needs of the Sheboygan County elderly population.[3] The intent of the Wellness Services and Educational Model Program is to provide a variety of direct services for the elderly, education programs related to self-care, and information about available community services. Horowitz specifies six characteristics central to the program:

1) The program advocates self-care as a key element to maintain elderly well-being;
2) The program consists of periodic screenings, health education, and information about health services;
3) It stresses breadth rather than depth of services;
4) Activities involve a variety of teaching methods;
5) It features a decentralized delivery system, coordinated with the congregate meal service, which was

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[2] Ilajean Horowitz, A Health Promotion Disease Prevention Model for the Elderly, (Master's Thesis, UW-Oshkosh, 1980), pp. 36-52.

[3] Ibid., p. 53.

mandated by the 1973 amendments to the Older Americans Act of 1965 (referred to as the Food and Fellowship Program in Sheboygan County);

6) It is directed by a central, local agency (Sheboygan County Office on Aging).[4]

After one and a half years of program implementation, the Director of the Sheboygan County Office on Aging requested the support of Judy Ladinsky, Ph.D., Professor of Preventive Medicine, and Jenifer Brown, graduate student in Social Planning, at the University of Wisconsin - Madison, to conduct an evaluative study of the Sheboygan County Wellness Services and Educational Model Program. The ensuing report is offered in response to this request, with the intent of determining the extent to which the program goals have been reached.

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[4]Ilajean Horowitz, A Health Promotion Disease Prevention Model for the Elderly, (Master's Thesis, UW-Oshkosh, 1980). pp. 54-63.

PART II METHODOLOGY

The Evaluation Instrument

In order to assess the effectiveness of the Wellness Services and Educational Model Program to date, as well as to provide information for future program planning, an evaluative survey was designed to yield the following information (refer to Appendix A for entire survey):

1) Adequacy of outreach attempts by program staff;
2) Overall Program effectiveness;
3) Participant satisfaction with the health education and information programs;
4) Participant satisfaction with the nutruition program;
5) Participant satisfaction with the excercise program;
6) Effectiveness of teaching methods employed;
7) Effectiveness of the annual Health Fair;
8) Topics of interest to the participant population;
9) Health Status of, and problems experienced by, the program participants.

The survey instrument relies heavily on individual perceptions of program effectiveness for a variety of reasons. Most notably, well-being is subjective in nature and cannot be measured in absolute terms. By measuring absolute change across variables of interest, a pre-test/post-test study is regarded as being the most conclusive means of determining the extent to which a program has effectively accomplished its objectives. The lack of existing operational indicators in defining well-being make a pre-test/post-test methodological design unsuitable for the evaluation of the Wellness Services and Educational Model Program. Additionally, pre-test/post-test designs are most often employed when the intent is to measure program outcomes.[5] As pointed out by Patton, the

[5] Michael Patton, Utilization-Focused Evaluation, (Beverly Hills, California: Sage Publications, Inc., 1978), p. 153.

tendency to overlook implementation evaluation often leads to results which fail to provide a direction for action because the decision-maker lacks information about what produced the observed outcomes (or lack of outcomes).[6] For this reason, evaluation questions have been framed in the context of program implementation; various program components are evaluated independently so that staff are aware of the contributions and deficiencies of each. This information will enable the staff to rationally develop and fine-tune future programs to most effectively meet the needs of the elderly participants. An overall measure of program outcomes — i.e., well-being among the elderly population — would lend little information as to which aspects of the program are causally related to the stated goals. Similarly, this information could not be gained from experimental control studies.

Additionally, a central premise of the program is that of individual choice in program participation. As purported by Horowitz, "the wellness model recognizes that the individual's behavior is the key to health promotion and disease prevention".[7] The individual must find the programs valuable and of interest, and choose to incorporate the information into his/her lifestyle in order for the desired goals of well-being and health maintenance to be attained. As the purpose of the evaluative study is to provide information to the staff for program development and planning, implementation evaluation has been employed in the study design.

The problem definition section of the survey lends some information as to

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[6] Michael Patton, Utilization-Focused Evaluation, (Beverly Hills, California: Sage Publications, Inc., 1978), p. 155.

[7] Ilajean Horowitz, A Health Promotion Disease Prevention Model for the Elderly, (Master's Thesis, UW-Oshkosh, 1980), p. 54.

the effectiveness of the program in promoting physical health among the participants, but again, the lack of pre-test measures makes it impossible to determine if program implementation has had either positive or negative effects. Rather, the primary purpose of this section is to provide information as to the specific health needs of the participant population. The Wellness Services and Educational Model Program was originally designed to address the problems and needs of the elderly which have been examined in the literature. While many characteristics are age-specific, a great deal of variability exists within age groups, and a needs assessment specific to the participant population will enable the staff to further fine-tune the program to meet the needs of their target population. Again, the needs and problems are identified by subjective measures. Implicit in the design is the assumption that interests and problems based on self-definition are more amenable to behavior change than are problems that have been identified by service providers. There are limitations in using subjective rather than objective measures of need: most notably, the lack of operational measures in defining need lends little information as to the incidence and/or prevalence of certain problems within the population. Furthermore, perceived problems reflect the norms and expectations of the population and therefore lack comparability to other population groups. However, while perceived need may not represent "real truth", it does provide the most useful indicator of potential demand for services.

Survey Implementation

The survey was administered at each of the eleven sites offering the Food

and Fellowship Program on Thursday, December 11, 1980, after the meal was completed. The survey was not announced to the participants in advance, so that attendance on the day of implementation would not be affected by this factor. Site staff were instructed not to discuss the survey with the participants, and to adhere to the specified procedure for implementing to the extent possible, to minimize possible bias which could influence participant responses. Participants were instructed to follow along as the site manager read aloud each survey question. Helpers were stationed around the room to aid people who had difficulty in hearing, reading, or understanding any questions or responses. Participants were asked to raise a hand to indicate when they had completed a question, and the site manager would begin reading the next question once all participants had completed the preceding question.

The site managers were asked to fill out a survey cover sheet which included general information about the site and the survey administration. They reported that the implementation of the survey in this manner took from 25 to 45 minutes, for an average of 35 minutes at the eleven sites. Although the majority of the participants completed the questionnaire under the standardized procedures, a few who had great difficulty in completing the survey were removed from the group and given individual aid in completing the questionnaire. Site managers from five of the sites reported that there were no problems encountered while the survey was administered, and that the participants were, for the most part, pleased to have the chance to share their opinions. However, the remaining six reported that some problems were encountered during the administration of the survey. Four site managers

indicated that a few of the respondents had difficulty understanding the Liekert-scaled response codes. Two managers felt they needed more individual help during the survey administration, and one indicated that the questionnaire was too lengthy for many of the participants.

With the strengths and weaknesses of the survey design in mind, the results of the Wellness Services and Educational Model Program evaluation were assessed by the following general approach.

Survey Analysis

Utilizing the Statistical Package for the Social Sciences (SPSS) for computer analysis of the survey results, raw frequencies are used as an indication of the perceived effectiveness of various program components and teaching methods. Similarly, raw frequencies are used to determine the magnitude of perceived health problems among the program participants, and as a basis of comparison between the perceived seriousness of the problems identified in the survey. The comparisons that are made may provide information for program staff to prioritize needs and problem areas for planning future programs. However, raw frequencies are not used independently to determine program effectiveness and to measure need. Moreover, the responses to specific questions are cross-tabulated with demographic variables of interest, or with responses to another question, as a way of determining who are satisfied with, or find deficiencies in, various program components. By doing so, the program staff will be able to determine if certain program components are weaker at some of the sites than others, and work to strengthen these. Similarly, the analysis will enable the staff to identify which, if any, population sub-

groups (e.g. the very old or individuals who are in very poor health) are or are not being effectively helped by the program.

Cross-tabulations are joint frequency distributions of cases according to two or more classificatory variables. A frequency count of 75% indicating that the information programs are excellent or above average may be interpreted as being favorable enought not to warrant program change. However, if when cross-tabulated with the variable "site", the 25% of the total sample population believing the information programs to be average or below in quality are all participants attending one site, serious deficiencies in this program component have been illuminated. Raw frequencies may obscure program inadequacies that are specific to certain subgroups of the participant population. Cross-tabulation allows for a more meaningful analysis of program components by narrowing the evaluation to specific groups.

The joint frequency distributions are statistically analyzed by the Chi-square test to determine whether or not the variables are statistically independent. As a measure of association between the variables, the Cramer's V statistic is used to describe the degree to which the values of one variable predict or vary with another. Only those relationships that are shown to be statistically significant (i.e. there is a high probability of "true" association between the variables which cannot be explained by chance alone) are discussed in the report. The total number of respondents for each question is reported in the joint frequency tables. In all cases, except where otherwise noted, the total number of responses for any one question that is discrepant from 453, the total number of questionnaires completed, is a result of questions that were not answered by some of the respondents (missing values). In these

cases, the percentages in the tables do not total 100%. However, the total number of respondents who answered the question are reported, as well as the number and percent falling into the response categories presented in the table.

Because of the problems discussed previously in using subjective measures of health problems, when possible, objective measures from secondary cources are used in conjunction with the survey results to illuminate more conclusively the health status of the Sheboygan County elderly population. As each approach has its strengths and limitations, the combination of the two may be helpful in assessing need as accurately as possible. Objective measures provide "hard" data of the incidence of problems in relation to problem incidence in comparable populations. Subjective measures may be more useful in planning for services, since they are often a measure of potential demand for services.

Representativeness of the Sample

The validity of the survey instrument is directly related to the representativeness of the sample population. Evaluative conclusions obtained from the questionnaire results may be generalized to the total participant population to the extent that the sample population accurately represents the population of interest. Demographic characteristics of the sample population are generally compared to those of the participant population to determine if certain subgroups have been excluded from the sample population. If the sample population does not proportionately represent the total participatn population across a varcity of demographic variables, then it is assumed that the pool of

respondents are a biased sample, and survey conclusions can only be generalized to the larger participant population with caution. Unfortunately, the Sheboygan County Office on Aging does not have data on the demographic characteristics of the total participant population. The site managers were asked to indicate the average number of people who usually attend their site on any one day, and to indicate the number of participants who ate the meal at their site on the day of the survey administration. As seen in table 1, the number of particpants attending the eleven sites on December 11, the day the survey was administered, approximates the number attending the sites on the average, with 87% of the average attendance. Of the 512 participants attending the Food and Fellowship program on the day of the survey, 453 participants completed the questionnaire. This represents 89% response rate for the survey, which is generally considered to be very high. There is no reason to assume that the slightly lower than average attendance on the day of the survey administration represents any systematic bias in the sampling procedure, since no prior announcement of the survey had been made and the weather was pleasnat. Therefore, we may assume the evaluation conclusions obtained from the sampling pool apply to the entire participant population of the Sheboygan County Food and Fellowship Program.

Table 1
Number of Participants Attending Sites on the Average and on Day of Survey, and Number Completing Survey

	Average Attendance	Attendance on Day of Survey	Number Completing Survey
St. Peter Claver	75	62	51
St. John's	120	101	90
Sheboygan Senior Center	60	38	38
Sheboygan Falls	40	26	24
Plymouth	40	41	29
Adell	30	26	26
Random Lake	30	30	26
Howard's Grove	38	18	15
Cedar Grove	25	26	26
Cascade	32	29	21
Oostburg	100	115	106
TOTAL	590	512	452*

*One Missing Value for Site of Attendance

PART III SURVEY RESULTS

Chapter 1 Outreach

Participant Characteristics

One way to evaluate the effectiveness of outreach attempts by program personnel is to compare demographic characteristics of the participant population with the comparable population of Sheboygan County. Since the target population for the Wellness Services and Educational Model Program encompasses all of the residents of Sheboygan who are 60 years of age or older and their spouses, the extent to which the participant population reflects the county elderly population across a variety of demographic variables will illuminate the deficiencies in the outreach program.

The following tables compare the survey respondents to the county population by the demographic variables of age and sex distribution, educational attainment, and occupation.

Table 2
1975 Estimates of Age Distribution of County Elderly Population*, and Age Distribution of Survey Respondents

Age	1975 County Population Estimates Percent	(n)	Survey Respondents Percent	(n)
60-64 years	27.7	(4810)	4.7	(21)
65-69 years	23.9	(4150)	19.4	(88)
70-74 years	19.4	(3368)	25.6	(116)
75-79 years	14.4	(2500)	23.8	(108)
80 years and over	14.6	(2535)	22.1	(100)
TOTAL	100.0	(17363)	95.6**	(433)

*Source: 1975 County Census Estimates, State of Wisconsin, Bureau of Aging, 1977.
**The remaining 4.4% represents 17 missing values (3.8%) and 3 (0.6%) individuals under the age of 60 among the respondents.

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Table 3
Sex Distribution of County Population*
and of Survey Respondents

Sex	1975 Population Estimates Percent	(n)	Survey Respondents Percent	(n)
Male	43.6	(7570)	38.2	(173)
Female	56.4	(9793)	58.3	(264)
TOTAL	100.0	(17363)	96.5**	(437)

*Source: 1975 County Estimates, State of Wisconsin, Bureau on Aging, 1977.
**The remaining 3 5% represents 16 missing values for the variable of sex.

Table 4
Years of School Completed by County Population*
and by Survey Respondents

Years of School Completed	Sheboygan County Population 25+ Percent	(n)	Survey Respondents Percent	(n)
8 Years or Less	34.1	(18043)	40.2	(182)
1-3 Years High School	14.4	(7613)	14.3	(65)
4 Years High School	36.4	(19230)	17.7	(80)
1-3 Years College	8.3	(4372)	7.3	(33)
4 Years College or More	6.9	(3626)	3.5	(16)
TOTAL	100.0	(52884)	83.0**	(376)
% High School Graduates	51.6		28.5	

*Source: 1970 Census, Detailed Characteristics of Wisconsin Population, U.S. Bureau of Census
**The remaining 17% represents 77 respondents who did not answer this question.

Table 5
Occupational Distribution of 1970 County Population*
Age 16 and Over and of Survey Respondents

Occupations	Sheboygan County % Total Employed	(n)	Survey Respondents % Total Employed	(n)
Professional, Technical and Kindred Workers	12.1	(5881)	12.6	(29)
Manager and Administrators Except Farm	6.6	(3206)	4.8	(11)
Sales Workers	7.5	(3648)	6.9	(16)
Clerical and Kindred Workers	18.8	(9148)	9.5	(22)
Craftsmen, Foremen, and Kindred Workers	1.3	(616)	13.4	(31)
Operatives, Except Transport	24.6	(11977)	21.2	(49)
Transport Equipment Operators	3.4	(1650)	1.7	(4)
Laborers, Except Farm	4.6	(2264)	7.4	(17)
Farmers	4.7	(2293)	14.3	(33)
Service Workers and Private Household Workers	16.5	(8066)	8.2	(19)
TOTAL	100.0	(48749)	100.0	(231)

*Source: 1970 Census, Detailed Characteristics of Wisconsin Population, U.S. Bureau of Census.

Based on 1975 estimates, Sheboygan County has a relatively high percentage of elderly residents. Of the estimated county population of 99,440 persons, 17,363 or 17.7% were 60 years and older in 1975. As seen in table 2, the participants in the Sheboygan County Food and Fellowship program are older than is true for the elderly population of the county as a whole. While 22.1% of the participants are 80 years or older, only 14.6% of the county elderly population are within this age group. Similarly, 23.8% of the program participants are between 75 and 79 years of age, compared to 14.4% among the county elderly population. And 25.6% of the participants are between 70 and 74 years of age, while only 19.4% of the county elderly are within this age range. Therefore, "younger" elderly persons are not represented in the pool of program participants to the extent that they comprise the county elderly population: 19.4% of the participants are between the ages of 64 and 69, compared to a proportion of 23.9% among the county elderly residents; and only 4.7% of the participants are 60 to 64 years old, while this age groups comprises 27.7% of the total county elderly population.

The fact that elderly participants do not proportionately represent the county elderly across age groups does not discredit the outreach attempts of the County Office on Aging. Because a major goal of both the nutritional programs and the Wellness Services and Educational Program is to foster functional independence and promote physical well-being among the elderly population in order to prevent needless institutionalization, the outreach program should be targeted to those elderly individuals who are most in need.

The majority of individuals in our nursing homes are over the age of seventy. And when not institutionalized, social isolation increases as one gets older; hence, it appears that it is primarily the very aged population which is in greatest need of community services. Based on the age-distribution of the program participants, Sheboygan County Office on Aging is doing a commendable job of reaching individuals over the age of 70, who are in greatest need of community services among the elderly.

As seen in table 3, men are slightly underrepresented in the pool of participants -- 38.2% vs. 43.6% among the county elderly population. Again, closer analysis demonstrates that the County Office on Aging may actually be targeting those in greatest need of services by having a relatively greater proportion of female participants than is seen in the county elderly population. In regards to the living situation of the program participants, 237 (52.3%) indicated that they live alone. Of these 237 individuals, 170 (72.6%) are females. Women tend to outlive men in the United States, and widowhood is associated with an increase of economic, social, and physical problems. To prevent physical deterioration and social isolation among this particularly vulnerable population, outreach attempts shoud be intensified for those elderly individuals who live alone. Empirical evidence indicates that the Sheboygan County Office on Aging has been successful in accomplishing this goal.

Problems exist in comparing the educational and occupational status of the participant population with that of the county population, since in the latter case, data could only be obtained for the general county population

and not specifically for the elderly. As seen in table 4, there are fewer participants who have completed one or more years of college (10.8%) than is true for the county population as a whole (13.2%). Similarly, only 17.7% of the participant population have completed high school as their highest level of educational attainment, compared to 36.4% of the general county population. However, it is impossible to determine from these statistics if the Sheboygan County Office on Aging is failing to reach higher-educated individuals to the extent that they exist in the population. Recent generations have been attending school for a much longer period than was true in the past; therefore, the county elderly population is probably less-educated than is the general county population, and this is undoubtedly reflected in the educational status of the participants of the Sheboygan County Food and Fellowship program.

Comparing county and participant occupational characteristics is similarly problematic because of the lack of county age-specific data. While professional, technical, and kindred workers are proportionately represented in the participant population (12.6%) to the extent that they are in general county population (12.1%), it is clear from table 5 that a great deal of variation exists between the county and participant distributions among the remaining occupational categories. Again, this phenomenon may be explained by societal trends, rather than deficiencies in the outreach component of the Wellness Services and Educational Model Program. For instance, only 9.5% of the survey respondents indicated that their primary occupation had been clerical in nature, compared to 18.8% of the county population in 1970. The large majority of secretaries, stenographers, and bookkeepers

are females, and females have only begun to enter the work force in large numbers in the last two decades. Hence, it is expected that clerical workers would represent a smaller proportion of occupations among the elderly than is true today. 14.3 percent of the respondents indicate that farming had been their primary occupation, while this was true for only 4.7% of the county population in 1970. Overrepresentation of this occupational group may not be a factor; rather the farm industry has been declining during the last 20 years in the entire state, as well as in the northeastern region, and one would expect a higher proportion of farmers among Wisconsin's elderly than is true for the general population.

Representation of county ethnic and racial minority population was not ascertained, since these groups comprise a very small proportion (0.51%) of the total county population. However, information regarding religion was not obtained from the survey; this could have illuminated whether certain religious groups are underrepresented among program participants.

Transportation Services

Lack of transportation often exists as a barrier to services for elderly individuals. For this reason, the Sheboygan County Office on Aging has allocated funding for the provision of transportation services for county elderly residents. Site "stagecoaches" traverse the county to transport all elderly individuals requesting service to and from the transportation sites. Additionally, the stagecoaches make weekly scheduled shopping trips for elderly residents. The Sheboygan County Office on Aging expressed interest in determining to what extent the stage coach service is being utilized by program particpants relative

to other means of transportation. The following transportation means are ranked by frequency of use in traveling to and from the nutrition sites in table 6, beginning with the most frequently used means of transportation.

Table 6
Means of Transportation Used by
Program Participants

Means of Transportation	Percentage Utilization Among Participants Percent	(n)
Own Car	53.6	(239)
Walk	21.3	(95)
Stagecoach	11.8	(52)
Ride with Someone Else	11.0	(49)
Public Transportation	2.3	(10)
TOTAL	100.0	(445)

For the most part, the participants appear to be transportationally self-sufficient, with only 25.1% indicating dependence on someone else, the stage-coach, or public transportation for rides to and from the program. Although data are not available to indicate the percentage of county elderly persons owning cars, according to the Southeastern Wisconsin Regional Planning Commission, only 35% of the state elderly residents have a car available to drive.[8] Although the percentage of elderly persons having a car available

[8] Southeastern Regional Planning Commission, Transportation Profile, 1978.

to drive in Sheboygan County may be higher than is true for the state in general, the proportion of Wellness Services and Educational Model Program participants having a car available (53.6%) seems disproportionately high.

Regional comparisons of transportation use among participants (table 7) provides evidence that the stagecoach is utilized to the greatest extent by participants attending the nutrition sites at the Sheboygan Senior Center (36.8%) and Plymouth (41.4%). Utilization of the stagecoach and any other means of public transportation is negligible at all other sites. Perhaps elderly residents are unaware of the availability of the stagecoach service, and those individuals who do not have a car available for use, are unable to drive, and/or cannot afford the costs of public transportation, are not attending the Wellness Services and Educational Model Program. The Sheboygan County Office on Aging may wish to explore further the possibility that lack of transportation is posing a barrier to access of the Wellness Services and Educational Model Program to many elderly county residents, and intensify their efforts to increase awareness and use of the stagecoach service.

Methods of Outreach

The Sheboygan County Office on Aging uses the following methods to inform county elderly residents of the Wellness Services and Educational Model Program: regular newspaper and radio advertising, church announcements, other agency referrals, and most recently, door-to-door staff visits. The Director of the Office on Aging was unaware of the relative effectiveness of each of these means of outreach. Table 8 ranks, in descending order, the ways

Table 7
Transportation Utilization of Program Participants
By Program Site N=445

Means of Transportation	St. Peter's % (n)	St. John's % (n)	Senior Center % (n)	Sheboygan Falls % (n)	Plymouth % (n)	Adell % (n)	Random Lake % (n)	Howard's Grove % (n)	Cedar Grove % (n)	Cascade % (n)	Costburg % (n)
Own Car	43.1 (22)	62.1 (54)	28.9 (11)	70.8 (17)	44.8 (13)	53.8 (14)	61.5 (16)	57.1 (8)	57.7 (15)	40.0 (8)	57.7 (60)
Ride With Someone Else	11.8 (6)	10.3 (9)	13.2 (5)	-- (0)	-- (0)	7.7 (2)	15.4 (4)	14.3 (2)	11.5 (3)	15.0 (3)	14.4 (15)
Walk	19.6 (10)	18.4 (16)	15.8 (6)	16.7 (4)	13.8 (4)	34.6 (9)	3.8 (1)	7.1 (1)	26.9 (7)	40.0 (8)	27.9 (29)
Public Transportation	2.0 (1)	4.6 (4)	5.3 (2)	4.2 (1)	-- (0)	3.8 (1)	-- (0)	7.1 (1)	-- (0)	-- (0)	-- (0)
StageCoach	23.5 (12)	4.6 (4)	36.8 (14)	8.3 (2)	41.4 (12)	-- (0)	19.2 (5)	14.3 (2)	-- (0)	5.0 (1)	-- (0)

Chi Square = $p < .001$
Cramer's V = .2440

in which participants indicate that they first become aware of the program.

Table 8
Methods of Outreach

Method	Percent	(n)
Friends or Family	61.1	(269)
Newspaper Advertisement	20.3	(92)
Staff Visit	7.9	(36)
Church Announcement	2.9	(13)
Radio Advertisement	2.9	(13)
Television Advertisement	0.9	(4)
TOTAL	94.3*	(437)

*5.7% missing values

Clearly, the participants are largely learning about the Food and Fellowship Program through family and friends, and unfortunately the ways in which these people are becoming aware of the service cannot be determined. (It should be noted that the agency does not utilize television as a means of program advertisement; it was used as a possible response category in the question related to outreach as a test of response validity. Since only 0.9% of the respondents marked this response, the question is considered to be a valid measure of determining effectiveness of outreach methods).

Crosstabulation of the outreach variable with the variable of site is useful in illuminating site differences in outreach attempts. Except for

Sheboygan Senior Center, Random Lake, and Howard's Grove, more than half of the participants at each site indicated that they first became aware of the Food and Fellowship Program from family and friends. Newspaper advertising appears to be an effective means of outreach at Sheboygan Senior Center, since 31.6% of the participants at this site became aware of the program through this means, and also at Random Lake, where 57.7% of the participants learned of the program through this means. The effects of all other outreach attempts were negligible at each site.

Because door-to-door solicitation of elderly residents by staff members is a relatively new component of program outreach, further attention will be given here as to its effectiveness. With only 7.9% indicating that they first learned of the program through a visit from a staff member, the attempt has been only minimally effective in stimulating program participation among elderly county residents. However, of all the sites, this outreach method has been most effective in Oostburg, having 17 of the total number (36) of respondents who indicated that staff visits were the primary way in which they learned of the Food and Fellowship Program. Less than five people at each of the ten other sites first became aware of the program through a visit from a staff person.

Chapter 2 Program Evaluation

Overview

There are various components to the Wellness Services and Educational Model Program, and because it is predicated on the premise of voluntary participation, identification of the primary reasons participants are attracted to the program is a useful evaluative measure. Since the health and wellness program has been incorporated into the ongoing elderly nutrition project in Sheboygan County, the noon meals and the opportunity for socialization are features of the program as well as the health, exercise, and community referral program components.

When asked to indicate the three most important reasons for attending the program, the distribution of responses fell with the following frequency:

Table 9

Reason	% Indicating 1st Most Important Reason %	(n)	% Indicating 2nd Most Important Reason %	(n)	% Indicating 3rd Most Important Reason %	(n)
To learn about services, events & classes in the community	9.1	(41)	3.8	(17)	18.3	(83)
To do the exercises	3.5	(16)	4.9	(22)	10.6	(48)
For the health education and information program	6.2	(28)	8.4	(38)	22.7	(103)
To eat the meal	37.3	(169)	28.0	(127)	7.7	(35)
To be with friends & other people	27.4	(124)	32.0	(145)	11.7	(53)

Clearly, the primary reason individuals are attending the sites is for the noon-time meal. In earlier conversations, Horowitz, the program director, related that she believed this to be the case. The nutrition program had been very popular with county elderly residents since its inception in 1974, and it was for this reason that the Wellness Services and Educational Model Program was incorporated into this existing program upon implementation. At the time of its development, County Aging Office personnel believed they could reach the greatest number of elderly individuals and increase program acceptance by incorporating the Wellness Services and Educational Model Program into the already successiul nutrition project.

The survey results indicate that the opportunity for socialization is also a very important reason for individuals to attend the program. Since isolation is associated with physical and emotional deterioration among elderly individuals, provision of socializing experiences is an important goal of the program which is being attained. With a total of 37.3% of the respondents indicating that the health and information programs is one of the three primary reasons for attending the program, and a total of 31.2% for the community referral service, these two program aspects are also important determinants of program attendance. Of the varied program components, the exercise program was cited by the fewest respondents (19.0%) as one of the three most important reasons for choosing to attend the Wellness Services and Educaiton Model Program.

As seen in table 10, the nutrition programs, and therfore, the Wellness

Services and Educational Model Programs do not operate five days per week at all eleven sites. As part of the evaluation study, program staff expressed an interest in determining if the programs are being offered frequently enough to meet the needs of program participants. Included in the survey was the question, "Do you think the meal program should be offered more frequently at your site?" In response, only 10.8% of the participants indicated the desire that the program be offered more frequently at their site, while 86.1% do not think this expansion of program frequency is necessary.

Table 10
Names of Sites and Days of Operation

St. Peter Claver Church	Monday through Friday
St. John's United Church	Monday through Friday
Sheboygan Senior Center	Monday through Friday
Sheboygan Falls Municipal Building	Monday through Friday
Plymouth	Monday through Friday
Adell	Monday through Friday
Random Lake	Tuesday and Thursday
Howard's Grove	Tuesday and Thursday
Cedar Grove	Monday and Thursday
Cascade	Friday
Oostburg	Wednesday

Although the total percentage of respondents desiring an increase in program frequency is minimal, closer analysis of the survey results illuminate particular subgroups expressing greater need in this respect. A sex association is apparent with this variable; 14.4% of the male respondents report that they would like to see the program offered more often at their

site, compared to only 8.1% of the females. And as seen in table 11, a larger percentage of participants who live alone (13.2%) report that they would like to see the program offered more frequently than participants who live with their spouses (7.1%), family (5.9%), or friends (0%). Interestingly, the sites which offer the program five days a week had the highest percentages of respondents indicating a desire to see the program offered more frequently. As table 12 evidences, the highest percentages of respondents indicating that they would like to see an increase in program frequency are at St. John's (20.7%), Plymouth (15.4%). and St. Peter's (14.9%). Cross-tabulation of this variable with that of additional days per week on which to offer the program indicates that the participants at St. John's, Plymouth, and St. Peter's would like to see program days extended to include Saturdays and Sundays. The entire results for analysis of additional days identified by participants will not be presented here for all the sites, since the total number indicating a desire to increase program frequency was so small at all sites but the three mentioned.

Table 11
Desire for Increase in Program Frequency
by Participant Living Situation
N=422

Desire for Increase in Program Frequency	Living Situation: Alone	With Spouse	With Family	With Friends
Yes	15.4 (36)	7.1 (12)	5.9 (1)	— (0)
No	84.6 (198)	92.9 (157)	94.1 (16)	100.0 (2)

Chi Square = $p < .10$
Cramer's V = .1663

Table 12
Desire for Increase in Program Frequency
According to Participant Site Attendance
N=438

esire for ncrease in rogram requency	St. Peter's % (n)	St. John's % (n)	Senior Center % (n)	Sheboygan Falls % (n)	Plymouth % (n)	Adell % (n)	Random Lake % (n)	Howards' Grove % (n)	Cedar Grove % (n)	Cascade % (n)	Oostburg % (n)
Yes	14.9 (7)	20.7 (18)	10.5 (4)	8.7 (2)	15.4 (4)	--- (0)	7.7 (2)	7.1 (1)	--- (0)	9.5 (2)	8.7 (9)
No	85.1 (40)	79.3 (69)	89.5 (34)	91.3 (21)	84.6 (22)	100.0 (26)	92.3 (24)	92.9 (13)	100.0 (26)	90.5 (19)	90.4 (94)

Chi Square = $p < .10$
Cramer's V = .1517

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Health Education and Information Programs

A central feature to the Wellness Services and Educational Model Program is the health education and information programs. Periodic presentations are conducted at the sites on a variety of health-related topics, including dental care, eye care, foot care, cancer prevention, cardiovascular problems, emergency preparedness, drug use and abuse, and economic/insurance issues. In her development paper for the Wellness Services and Educational Model Program, Horowitz wrote, "Since elderly people are heterogeneous and have different physical, emotional, and social needs, our aim is to expose them to the whole range of wellness services and information and let them choose what is of value to them. Usually, an introduction into the subject is all they will tolerate. If a topic is approached in depth, many will have not interest, some will lose interest, and others will actually walk out. Therefore, our objective is to introduce them to the material and only offer it in greater depth if we determine that they want more information on a particular subject".[9] The reader may refer to Appendix II for the complete list of program topics that are included in the model program, as well as for the frequency that the Sheboygan County Office on Aging attempts to offer each program at the eleven sites.

Methods of program presentations are varied (this will be covered in greater detail in the section of this chapter devoted to teaching methodology),

[9] Ilajean Horowitz, A Health Promotion Disease Prevention Model for the Elderly, (Master's Thesis, UW-Oshkosh, 1980), p. 56.

and staff have related in conversations that there have been some problems soliciting the assistance of community professionals to present information on specific topics. In several instances, a professional from the community has volunteered his/her services, but has failed to continue out his/her scheduled activity at all eleven sites. Horowitz offered several plausible explanations for the problems of securing professional assistance to the program: 1) a general disease-model orientation to physical health exists among community professionals, rather than one of wellness and prevention; 2) when adherence to a prevention model is prevalent, there often is a belief on the part of community professionals that such an approach is suitable for the young and middle-aged, but not for the elderly; 3) a general lack of commitment/interest on the part of community professionals in working with older people; 4) many community professionals have expressed frustration in that much of the material they present seems to be of little interest to, and is not assimilated by, the participants.

Although experiences with many of the community professionals have been successful, the problem exists to the extent that the activities have not been executed as frequently as originally proposed at the time of the development of the model program (see Appendix II). However, analysis of the program schedule for a period of six months demonstrates that information program presentations occur least weekly at each site, and at a frequency that closely approximates the ideal schedule.

The results of the survey provide evidence that the health information programs have been very successful. 88.5% of the participants responded "yes"

to the question "Do you find the information programs helpful to you?" When asked to rate the program on a Liekert scale, 49.9% rated the information programs as being excellent, 43.7% rated them as being satisfactory, and only 0.9% rated them as being poor. 87.9 percent said they would like to see the health information programs continued in the future.

Because variation undoubtedly exists between the information programs at different sites, the survey questions related to this aspect of the model program has been crosstabulated with the variable "site". As seen in table 13, the large majority of participants find the information programs useful to them at all eleven sites; however, the largest percentages not finding them useful attend the Sheboygan Senior Center (13.2%), Adell (21.7%), and Oostburg (15.0%). Table 14 indicates that over half of the participants have rated the health information programs as excellent at all eleven sites but four: a satisfactory rating was given by 60.9% of the participants at Sheboygan Falls, 65.2% at Adell, 76.9% at Cedar Grove, and 65.7% at Oostburg. The percentage of respondents rating the program as poor was minimal at all eleven sites. Similarly, the majority of respondents at all eleven sites indicated that they would like to see the information programs continued in the future; however, the highest percentages indicating they would not like to see the program continued in the future were the respondents at Adell (20.8%), Cedar Grove (11.5%), and Oostburg (21.2%) (table 15).

No associations were ascertained between the participant evaluations of the health information programs and the demographic variables of sex, age, occupation, or living situation. However, the ratings of the programs are

associated with the participants' educational levels. As seen in table 16, the percentages of excellent ratings decrease as the participants' educational levels increase. While 60.1% of the respondents having completed eight years of schooling or less rated the information programs as excellent, a like response was obtained from only 43.1% of the respondents with nine to eleven years of schooling, 42.0% of those having graduated from high school, 42.4% of the respondents with one to three years of college, and 31.3% of participants who have completed college and/or have had post-graduate experience. The participant evaluations of the health informa- programs also vary with the health status of the individual. The way in which this factor was derived is examined in detail in Chapter 3. Essentially, a health status index was derived from the problem identification section of the survey, such that 20.6% of the participants experiencing many problems and/or with great severity were identified as "high risk" individuals, 46.6% having a moderate number of health-related problems or a low number of problems of great severity were identified as "moderate risk" individuals, and 32.8% experiencing a very few number of health problems were identified as being "low risk" individuals. As seen in tables 17 and 18, both the perception of the usefulness of the health information programs, as well as the desire to see the program continued in the future, are associated with this health status index. Paradoxically, the percentage of respondents indicating that they find the information programs are very useful to them is highest among "high risk" individuals (95.6%), decreases to 92.7% among the "moderate risk" individuals, and is lowest (87.4%) among the "low risk" individuals.

The percentages are exactly the same across categories of health status according to the desire to see the information programs continued into the future. One can only speculate as to the factors emerging here. One possible explanation could be that those people who are in poorer health see more relevance in learning about specific problem areas than do their healthier contemporaries. But overall, it is important to emphasize that the health information programs have been favorably received by the majority of all the participants, and appears to be a strong component of the Wellness Services and Educational Model Program.

When asked in an open-ended question, what, if any, information programs have been particularly helpful, 180 people responded with a wide variety of topics. The most frequently cited programs as being particularly useful were those related to weight loss and diet, high blood pressure, the programs having to do with social security which were presented by Bob Slattery, and programs that were presented by Karen Sorens, public health nurse.

Table 13
Perceived Usefulness of Health Information Programs
by Participant Site Attendance
N=437

e Infor- ation Pro- ams Useful You?	St. Peter's % (n)	St. John's % (n)	Senior Center % (n)	Sheboygan Falls % (n)	Plymouth % (n)	Adell % (n)	Random Lake % (n)	Howard's Grove % (n)	Cedar Grove % (n)	Cascade % (n)	Oostburg % (n)
Yes	100.0 (49)	96.7 (87)	86.8 (33)	91.3 (21)	96.3 (26)	78.3 (18)	100.0 (26)	93.3 (14)	92.3 (24)	90.0 (18)	85.0 (85)
No	--- (0)	3.3 (3)	13.2 (5)	8.7 (2)	3.7 (1)	21.7 (5)	--- (0)	6.7 (1)	7.7 (2)	10.0 (2)	15.0 (15)

Chi Square = $p < .10$
Cramer's V = .1752

Table 14
Rating of Information Program by Participant Site Attendance
N=436

Rating of Information Programs	St. Peter's % (n)	St. John's % (n)	Senior Center % (n)	Sheboygan Falls % (n)	Plymouth % (n)	Adell % (n)	Random Lake % (n)	Howard's Grove % (n)	Cedar Grove % (n)	Cascade % (n)	Oostburg % (n)
Excellent	64.7 (33)	76.7 (69)	51.4 (19)	39.1 (9)	60.7 (17)	30.4 (7)	53.8 (14)	57.1 (8)	23.1 (6)	63.2 (12)	32.3 (32)
Satisfactory	35.3 (18)	23.3 (21)	48.6 (18)	60.9 (14)	35.7 (10)	65.2 (15)	46.2 (12)	42.9 (6)	76.9 (20)	36.8 (7)	65.7 (65)
Poor	--- (0)	--- (0)	--- (0)	--- (0)	3.6 (1)	4.3 (1)	--- (0)	--- (0)	--- (0)	--- (0)	2.0 (2)

Chi Square = $p < .001$
Cramer's V = .2724

Table 15
Desire of Health Information Program Continuance
Participant Site Attendance
N=435

Desire for Information Program Continuance in the Future	St. Peter's % (n)	St. John's % (n)	Senior Center % (n)	Sheboygan Falls % (n)	Plymouth % (n)	Adell % (n)	Random Lake % (n)	Howard's Grove % (n)	Cedar Grove % (n)	Cascade % (n)	Oostburg % (n)
Yes	100.0 (50)	97.8 (87)	92.1 (35)	95.5 (21)	96.4 (27)	79.2 (19)	100.0 (26)	92.9 (13)	88.5 (23)	94.7 (18)	78.8 (78)
No	--- (0)	2.2 (2)	7.9 (3)	4.5 (1)	3.6 (1)	20.8 (5)	--- (0)	7.1 (1)	11.5 (3)	5.3 (1)	21.2 (21)

Chi Square = $p < .001$
Cramer's V = .2946

Table 16
Rating of Health Information Program
by Participant Educational Level
N=371

Rating of Information Program	Years of School Completed: 8 Years or Less % (n)	9-11 Years % (n)	High School Graduate % (n)	1-3 Years College % (n)	College Graduate + % (n)
Excellent	60.1 (107)	43.1 (28)	43.0 (34)	42.4 (14)	31.3 (5)
Satisfactory	39.4 (37)	56.9 (37)	54.4 (43)	54.5 (18)	68.8 (11)
Poor	— (0)	— (0)	2.5 (2)	3.0 (1)	— (0)

Chi Square = $p < .01$
Cramer's V = .1611

Table 17
Perceived Usefulness of Health Information Program
According to Participant Health Status N=438

Do you find the Information Program Useful?	Health Status: High Risk % (n)	Moderate Risk % (n)	Low Risk % (n)
Yes	95.6 (86)	92.7 (190)	87.4 (125)
No	4.4 (4)	6.8 (14)	12.6 (18)

Chi Square = $p < .10$
Cramer's V = .1023

Table 18
Desire of Health Information Program Continuance
by Participant Health Status
N=436

Desire for Information Program Continuance	Health Status: High Risk %	(n)	Moderate Risk %	(n)	Low Risk %	(n)
Yes	95.6	(86)	92.1	(187)	87.4	(125)
No	4.4	(4)	7.9	(16)	12.6	(18)

Chi Square = p $\angle$.10
Cramer's V= .1064

Nutrition Program

As part of the Wellness Services and Educational modal Program, information on nutrition is presented each day of program operation at all eleven sites. The information is presented in the form of nutrition tips passed on by site managers, in the form of quizzes and/or group discussions. As a measure of program success, the nutritional program has been rated favorably by the survey respondents. 85.7 percent of the respondents have found the nutrition information to be useful to them and 80.6% would like to see this aspect of the program continued in the future. When examining the responses according to site attendance (table 19), more than half of

the respondents at all eleven sites find the nutrition tips helpful, although the highest percentage who do not find them to be helpful are among those at Sheboygan Falls (23.8%), Adell (20.8%), Cedar Grove (15.4%), and Oostburg (17.5%). Similarly, the percentages expressing a desire to see the information program were high at all eleven sites, although lowest at Sheboygan Falls, where 14.3% do not want to see the nutrition program continued; Adell, where 17.4% do not want to see it continued; Cedar Grove, having 16% indicate that they don't want to see the program continued; and Oostburg, where 25% of the respondents would like to see the nutrition program discontinued (table 20). Other than site of attendance, no other associations were ascertained between the evaluations of the nutrition program and various participant characteristics. As was true with the health information program, the nutrition program is largely regarded as beneficial by program participants.

Table 19
Perceived Usefulness of Nutrition Program
by Participant Site Attendance
N=430

o you find utrition rogram seful to you?	St. Peter's % (n)	St. John's % (n)	Senior Center % (n)	Sheboygan Falls % (n)	Plymouth % (n)	Adell % (n)	Random Lake % (n)	Howard's Grove % (n)	Cedar Grove % (n)	Cascade % (n)	Oostburg % (n)
Yes	98.0 (49)	92.1 (82)	97.4 (37)	76.2 (16)	96.3 (26)	79.2 (19)	100.0 (26)	100.0 (12)	84.6 (22)	90.0 (18)	82.5 (80)
No	2.0 (1)	7.9 (7)	2.6 (1)	23.8 (5)	3.7 (1)	20.8 (5)	--- (0)	--- (0)	15.4 (4)	10.0 (2)	17.5 (17)

Chi Square = $p < .01$
Cramer's V = .2470

Table 20
Desire for Nutrition Program Continuance
by Participant Site Attendance
N=404

Desire for Program Continuance	St. Peter's % (n)	St. John's % (n)	Senior Center % (n)	Sheboygan Falls % (n)	Plymouth % (n)	Adell % (n)	Random Lake % (n)	Howard's Grove % (n)	Cedar Grove % (n)	Cascade % (n)	Oostburg % (n)
Yes	98.0 (49)	95.4 (83)	92.1 (35)	85.7 (18)	92.3 (24)	82.6 (19)	100.0 (25)	100.0 (13)	84.0 (21)	100.0 (20)	75.0 (57)
No	2.0 (1)	4.6 (4)	7.9 (3)	14.3 (3)	7.7 (2)	17.4 (4)	--- (0)	--- (0)	16.0 (4)	--- (0)	25.0 (19)

Chi Square = $p < .001$
Cramer's V = .2956

Exercise Program

Physical activity is widely regarded as an important determinant in achieving and maintaining health and well-being among all age groups. To promote this tenet, exercises are an important aspect of the Wellness Services and Educational Model Program, and are led by site managers or participant volunteers each day of program operation. As are all of the program components, the exercises are optional, and participants choose whether or not to take part in the daily exercises. The survey results provide evidence that the exercise program component has been fairly successful, with 67.8% of all respondents indicating that they believe the exercises have been helpful to them, and 72.0% responding that they would like to see the exercises continued in the future. As seen in table 21, the percentages indicating that they perceive the exercises as being useful is high at all of the sites except four: at Sheboygan Falls, 30.4% do not find the exercises helpful; 42.3% of the respondents at Cedar Grove do not believe the exercises are useful; 25.0% of the respondents at Cascade believe this is the case; and at Oostburg, 67.7% of the respondents indicated that they do not find the exercises to be of any use. A similar pattern is seen in the desire to have the exersies program continued in the future (table 22). At all sites, the majority of the repsondents would like to see this program component continued in the future, however, a substantial number do not want to see the exercise program continued at Sheboygan Falls (21.7%), Cedar Grove (36.0%), and Oostburg (67.8%).

No associations are apparent between the evaluation of the exercise pro-

gram and the variables of age, sex, and living situation; however, an association is seen with participant educational level (table 23). The desire to see the exercise program continued in the future is inversely related to participant educational attainment. Among those participants having completed eight years of school or less, 82.3% would like to see the exercise program continued; 72.6% of those participants who have completed nine to eleven years of school gave a similar response; 77.0% who have completed high school expressed a desire to see the exercise program continued; 66.7% gave this response among those participants who have had one to three years of college; and 60.0% of those who have completed college and/or have post-graduate training would like to see the exercise program continued in the future.

Although the exercise program has not received acceptance by the participants to the extent that the health information and nutrition programs have, in general, the evaluation of this program component is favorable among participants of the Wellness Services and Educational Model Program. While the other program components requrie mental participation in order to be effective, the exercises are the program component which requires physical participation. This may in part explain why the exercises have not been accepted to the extent that the other program components have; Americans have only recently recognized the value of exercise in living a healthy life, and despite this recognition, individuals have been reluctant to change their behavior to reflect this knowledge.

Table 21
Perceived Usefulness of Exercise Program
by Participant Site Attendance
N=423

Do you think the exercises are useful?	St. Peter's % (n)	St. John's % (n)	Senior Center % (n)	Sheboygan Falls % (n)	Plymouth % (n)	Adell % (n)	Random Lake % (n)	Howard's Grove % (n)	Cedar Grove % (n)	Cascade % (n)	Oostburg % (n)
Yes	88.0 (44)	86.0 (74)	91.4 (32)	69.6 (16)	85.2 (23)	91.7 (22)	87.5 (21)	93.3 (14)	57.7 (15)	75.0 (15)	32.3 (30)
No	12.0 (6)	14.0 (12)	8.6 (3)	30.4 (7)	14.8 (4)	8.3 (2)	12.5 (3)	6.7 (1)	42.3 (11)	25.0 (5)	67.7 (63)

Chi Square = $p < .001$
Cramer's V = .5122

Table 22
Desire for Exercise Program Continuance
According to Participant Site Attendance
N=420

Desire for Exercise Program Continuance	St. Peter's % (n)	St. John's % (n)	Senior Center % (n)	Sheboygan Falls % (n)	Plymouth % (n)	Adell % (n)	Random Lake % (n)	Howard's Grove % (n)	Cedar Grove % (n)	Cascade % (n)	Oostburg % (n)
Yes	96.0 (48)	88.8 (79)	94.4 (34)	78.3 (18)	96.4 (27)	95.5 (21)	88.0 (22)	93.3 (14)	64.0 (16)	90.0 (18)	32.2 (28)
No	4.0 (2)	11.2 (10)	5.6 (2)	21.7 (5)	3.6 (1)	4.5 (1)	12.0 (3)	6.7 (1)	36.0 (9)	10.0 (2)	67.8 (59)

Chi Square = $p < .001$
Cramer's V = .5817

Table 23
Desire for Continuance of Exercise Program
According to Participant Educational Level
N=359

Desire for Exercise Program Continuance	Years of School Completed: 8 Years or Less % (n)	9-11 Years % (n)	High School Graduate % (n)	1-3 Years College % (n)	College Graduate+ % (n)
Yes	82.3 (144)	72.6 (45)	77.0 (57)	66.7 (22)	60.0 (9)
No	17.7 (31)	27.4 (17)	23.0 (17)	33.3 (11)	40.0 (6)

Chi Square = p $<$ .10
Cramer's V = .21.3

Methods of Presentation

A major premise of the Wellness Services and Educational Model Program, according to Horowitz, is that a varied teaching methodology is the optimum approach in presenting inforamtion to elderly persons.[10] Because many elderly individuals cannot hear well, cannot see well, have short attention spans, and have little formal education, the ideal is to present information both orally and in written form, and to keep it simple and brief. The Wellness

[10] Ilajean Horowitz, A Health Promotion Disease Prevention Model for the Elderly, (Master's Thesis, UW-Oshkosh, 1980). pp. 58-59.

Services and Educational Model Program approaches to relating health information has included brief lectures by experts, presentations by peers and site managers, quizzes, charts, posters, brochures, newsletters, games, and audio-visuals. The relative effectiveness of teaching modes has been measured as part of the Wellness Services and Educational Model Program evaluative study.

The participants were asked to rank on a Liekert scale six teaching methods utilized by the model program, according to the perceived effectiveness of each. The frequency distribution of the ranked responses are presented in table 24. The data indicates that the program participants believe that presentations by community professionals has been the most effective teaching methodology employed by the program, since this category received the highest percentage of "most effective" responses (38.6%), as well as "second most effective" responses (21.4%). Group discussions is perceived as the second most effective teaching methodology, with 20.1% of the participants ranking it as the best method and 18.5% ranking it as the second best mode of teaching. Ranked third among most effective teaching methodologies by the participants are movies, with 14.3% ranking it highest, and 18.5% ranking it second highest. Presentations by staff members ranked fourth among the six teaching methodologies; 8.6% believe it is the most effective method, and 16.3% believe it is the second most effective, and 18.3% think it is the third most effective teaching method among those listed. Pamphlets and reading materials appear to be the fifth most preferred teaching methodology, and quizzes and games as a teaching methodology is ranked as being the least effective mode of teaching by the program participants.

Table 24

Frequency Distribution of the Perceived Effectiveness of the Model Program Teaching Methodologies

Methods of Presentation	Most Effective Method	2nd Most Effective Method	3rd Most Effective Method	4th Most Effective Method	5th Most Effective Method	Least Effective Method
Group Discussions	20.1 (91)	18.5 (84)	11.5 (52)	6.8 (31)	6.2 (28)	8.2 (40)
Presentations by Community Professionals	38.6 (175)	21.4 (97)	7.9 (36)	3.1 (14)	3.1 (14)	2.2 (10)
Quizzes and Games	5.3 (24)	10.4 (47)	14.6 (66)	9.7 (44)	12.4 (56)	18.8 (85)
Movies	14.3 (65)	18.5 (84)	14.6 (66)	13.7 (62)	6.2 (28)	8.4 (38)
Presentations by Site Staff	8.6 (39)	16.3 (74)	18.3 (83)	11.9 (54)	12.6 (57)	5.7 (26)
Pamphlets & Reading Material	7.3 (33)	13.9 (63)	10.2 (46)	9.1 (41)	11.9 (54)	19.0 (90)

The rankings of the two most effective teaching methodologies, community professional presentations and group discussions, show associations with the educational characteristics of the respondents. As seen in table 25, the percentage who ranked community professional teaching methodology as "the most effective" increases as the educational level of the participants increase. 41.8 percent ranked this mode of teaching as the most effective among partici-

pants having an eighth grade education or less, compared to 51.8% of those who have completed nine to eleven years of school, 66.7% of those who have completed high school, 66.7% of those who have completed one to three years of college, and 57.1% of those who completed college and/or have had post-graduate training. Table 26 shows an inverse relationship apparent between the perceived effectiveness of group discussions as a teaching methodology and the educational level of the participants. The percentage of respondents who ranked this methodology as the most effective increases as the educational level of the respondents decreases. 33.3% of those respondents who have completed eight years of school or less ranked this teaching methodology as the most effective, compared to 30.6% who have completed nine to eleven years of school, 21.1% of those who are high school graduates, 12.0% of those who have completed one to threee years of college, and only 7.1% of those with at least a college degree.

The survey results for the evaluation of the teaching methodologies substantiates the information related by the participants when asked to comment on any health information programs which had been particularly helpful to them. As discussed previously in the section concerning the health education and information programs, the most frequently cited programs as being particulary outstanding were those led by Karen Sorens, public health nurse, and Bob Slattery, who presented information on social security. While the County Office on Aging has experienced some difficulty in eliciting the support of a few community professionals, the experiences with some have been extremely successful. From the open-ended responses elicited from the participants by

the question, "What, if any, information programs have been particularly helpful to you?" indeed, the topics presented by community professionals have apparently made the greatest impression upon the participants, and have been a particularly outstanding feature of the Wellness Services and Educational Model Program.

Table 25
Perceived Effectiveness of Community Professional Presentations as a Teaching Methodology According to Participant Educational Level N=308

Ranking of Effectiveness	Years of School Completed: 8 Years or Less % (n)	9-11 Years % (n)	High School Graduate % (n)	1-3 Years College % (n)	College Graduate + % (n)
First	41.8 (56)	51.8 (29)	66.2 (49)	66.7 (20)	57.1 (8)
Second	32.8 (44)	31.1 (18)	17.6 (13)	16.7 (5)	14.3 (2)
Third	13.4 (18)	12.5 (7)	4.1 (3)	6.7 (2)	7.1 (1)
Fourth	6.0 (8)	1.8 (1)	5.4 (4)	— (0)	— (0)
Fifth	2.2 (3)	1.8 (1)	5.4 (4)	10.0 (3)	14.3 (2)
Sixth	1.6 (5)	— (0)	1.4 (1)	— (0)	7.1 (1)

Chi Squre = $p < .05$
Cramer's V = .1694

Table 26
Perceived Effectiveness of Group Discussions
as a Teaching Methdology According
Participant Educational Level
N=291

Ranking of Effectiveness	Years of School Completed: 8 Years or Less % (n)	9-11 Years % (n)	High School Graduate % (n)	1-3 Years College % (n)	College Graduate + % (n)
First	33.3 (44)	30.6 (15)	21.1 (15)	12.0 (3)	7.1 (1)
Second	25.8 (34)	20.4 (10)	29.6 (21)	16.0 (4)	35.7 (5)
Third	18.9 (25)	14.3 (7)	12.7 (9)	24.0 (6)	21.4 (3)
Fourth	3.8 (5)	12.2 (6)	8.5 (6)	24.0 (6)	21.4 (3)
Fifth	6.8 (9)	10.2 (5)	12.7 (9)	4.0 (1)	14.3 (2)
Sixth	11.4 (15)	12.2 (6)	15.5 (11)	20.0 (5)	--- (0)

Chi Square = $p < .05$
Cramer's V = .1648

Health Fair

Coordinated with health education and information services which are offered at the Food and Fellowship sites is an annual health fair. The health fair features screenings recommended for older persons, consultations with public health nurses, and health information all available in one location on a single day (see Appendix III). In her model program plan, Horowitz states that the purpose of this activity is "to point up the importance of

a yearly check-up and also to expose the elderly to a myriad of information that may be useful to them."[11] Exhibits are promoted at the Food and Fellowship sites prior to the fair to stimulate interest in them. Coordination is further enhanced by having nurses follow-up on those persons screened at the health fair who need more attention by seeing them at the Food and Fellowship sites. This plan also maximizes use of resources by enabling nurses to attend to several clients during one visit to the nutrition site, rather than having to make several home visits for this purpose.

Of the 453 respondents, 32% went to the health fair held the previous spring. Of those who attended, 78.0% found the health fair information useful. Table 27 illustrates that the sites having the smallest percentages of participants attending the health fair were at Random Lake (24%), Cedar Grove (26.9%), Cascade (20%), and Oostburg (24.4%). There are several possible explanations for this. Perhaps the distance from these sites to the location of the health fair in Sheboygan Falls is a deterrent from attendance of this event by many of the elderly residents living in these towns. If this is the case, intensification of transportation services on this day by the County Office on Aging could alleviate this problem. Perhaps, promotion of the health fair did not occur at these four sites for the same duration or of similar magnitude that occurred at the other

[11] Ilajean Horowitz, A Health Promotion Disease Prevention Model for the Elderly, (Master's Thesis, UW-Oshkosh, 1980), p.55.

seven sites. The County Office on Aging may wish to increase their efforts at promoting the health fair at these sites in the future. Lastly, one factor which may be emerging in explanation of decreased health fair attendance from certain sites is that the populations of these sites may be qualitatively different than those of the other sites. It is unknown to what extent this is true, but age variation, income or education differences, and other life experiences could be associated with a decreased interest in and/or need for health fair services.

With respect to the health status of the participants, it appears that the health fair is reaching those persons most in need of services. As seen in table 28, the persons who are experiencing the greatest number of health problems and/or of the worst severity were more likely to attend the health fair (41.1%) than those who are at moderate risk for health problems (33.3%), or at low risk (28.8%). Perhaps those people who are in poorer health perceive the services provided at the health fair to be of more value than do their healthier contemporaries. Because the model emphasizes primary prevention of disease in lieu of secondary or tertiary treatment of disease, the County Office on Aging should intensify its efforts to encourage the use of preventive services among all elderly program participants, regardless of one's present manifestations of problem symptoms.

An association is apparent between the perceived usefulness of the health fair services and the sex of the participant. Of those respondents who attended the health fair, the men found the sevices offered at the health fair to be useful to a greater extent (94.6%) than did the women who attended

the health fair (74.1%) (table 29).

To evaluate the relative effectiveness of the various components of the health fair, the participants were asked to rank order the seven central program areas that were included in the health fair. The results of the program rankings are presented in table 30. Clearly, the screening and testing procedures performed by the public health nurses is considered to be the most effective feature of the health fair program by the Wellness Services and Educational Model participants. The percent ranking this as the most effective program component (59.5%) is much higher than for any other category. The physical health information program received the next highest percentage of "most effective" ratings (32.4%). With the third highest percentage of "most effective" ratings (13.9%), and a substantial percentage of "second most effective" ratings, the environmental health information category places third in the relative ratings of health fair services. Although little variation is apparent in the rankings for the remaining four service categories, it appears that the mental health information program is perceived to be the fourth most effective program category by the participants, information on recreation and exercises received a relative ranking of five, counseling and referrals has been ranked number six, and the health history program is perceived as being the least effective service provided at the Sheboygan County health fair.

By offering services which cannot be provided at the nutrition sites, covering in greater depth topics which are presented at the sites, and assessing health status of participants, the health fair is an important feqture of the Wellness Services and Educational Model Program. The evalua-

tion provides evidence that the services provided at the health fair have been very effective among those participants who attended the health fair, particularly the screening and testing program and the health information program. However, with only one third of the Wellness Services and Educational Model Program participants attending the health fair, the greatest weakness of the program has been in the ability to stimulate interest and attendance among participants by staff of the County Office on Aging. Intensification of outreach, prior health fair promotion at the nutrition sites, media advertisement, and transportation provisions may increase health fair attendance in the future.

Table 27
Health Fair Attendance by Participant Nutrition Site Attendance
N=432

Did you go to the health fair?	St. Peter's % (n)	St. John's % (n)	Senior Center % (n)	Sheboygan Falls % (n)	Plymouth % (n)	Adell % (n)	Random Lake % (n)	Howard's Grove % (n)	Cedar Grove % (n)	Cascade % (n)	Oostburg % (n)
Yes	45.8 (22)	37.2 (32)	38.9 (14)	30.4 (7)	42.9 (12)	38.5 (10)	24.0 (6)	46.7 (7)	26.9 (7)	20.0 (4)	24.2 (24)
No	54.2 (26)	62.8 (54)	61.1 (22)	69.6 (37)	57.1 (16)	61.5 (16)	76.0 (19)	53.3 (8)	73.1 (19)	80.0 (16)	75.8 (75)

Chi Square = $p < .10$
Cramer's V = .1792

Table 28
Health Fair Attendance According
to Participant Health Status
N=433

Did you go to the Health Fair?	Health Status: High Risk % (n)	Moderate Risk % (n)	Low Risk % (n)
Yes	41.1 (37)	33.3 (68)	28.8 (40)
No	58.9 (53)	66.7 (136)	71.2 (99)

Chi Square = $p < .10$
Cramer's V = .1603

Table 29
Perceived Usefulness of Health Fair Services Among Those
Who Attended the Health Fair According to Sex of Participant
N=140

Did you find the health fair information helpful?	Sex: Male % (n)	Female % (n)
Yes	94.6 (53)	74.1 (63)
No	5.4 (3)	24.7 (21)

Chi Square = $p < .001$
Cramer's V = .2638

Table 30
Frequency Distribution of the Participant Rankings
of the Health Fair Program Components

Program Categories	Effectiveness Rankings						
	First	Second	Third	Fourth	Fifth	Sixth	Least
Environmental Information	13.9 (15)	20.4 (22)	18.5 (20)	13.9 (15)	11.1 (12)	9.3 (10)	13.0 (14)
Physical Health Information	32.4 (36)	26.1 (29)	19.8 (22)	12.6 (14)	4.5 (5)	2.7 (3)	1.8 (2)
Mental Health Information	8.4 (9)	11.2 (12)	11.2 (12)	12.1 (13)	18.7 (20)	18.7 (20)	19.6 (21)
Information on Recreation & Exercises	6.7 (7)	5.7 (6)	12.4 (13)	13.3 (14)	19.0 (20)	20.0 (21)	22.9 (24)
Screening & Testing	59.5 (66)	14.4 (16)	8.1 (9)	7.2 (8)	2.7 (3)	4.5 (5)	3.6 (4)
Health Histories	1.5 (7)	11.4 (12)	16.2 (17)	16.2 (17)	18.1 (19)	18.1 (19)	13.3 (14)
Counseling & Referrals	3.7 (4)	29.4 (32)	16.5 (18)	11.9 (13)	9.2 (10)	13.8 (15)	15.6 (17)

Chapter 3 Need Assessment

The success of the Wellness Services and Educational Model Program is predicated on voluntary participation on the part of the target population. The goals of the model program, thereofre, can only be attained to the extent that the program components address the interests of, and accurately reflect the needs of, county elderly residents. While Horowitz conducted an extensive review of the literature as to the needs and concerns of elderly individuals prior to the development of the model plan, the findings are relative to elderly persons in general, and are not specific to the Sheboygan County elderly population.[12] Elderly people have one thing in common -- they are, by definition, over the age of sixty -- beyond this, they are a hetereogenous group, manifesting a wide variety of characteristics, interests, habits, lifestyles, attitudes, problem areas, and the like. As a basis for planning and developing future Wellness Services and Educational Model Program activities, a needs assessment study has been incorporated into the evaluative survey with the purpose of determing the interest of, and the extent and characteristics of the areas of dysfunction, amon the target population. The approach is limited in that it assesses the interests and needs of the participant population as a whole, rather than the entire county elderly population, which is truly the target population. However, the assessment may provide one important informational input to a much broader planning process that may

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[12] Ilajean Horowitz, A Health Promotion Disease Prevention Model for the Elderly, (Master's Thesis, UW-Oshkosh, 1980),pp. 12-36.

lead to a) the selection of and priority setting among problems and issues to be addressed; b) the development and operationalization of specific program activities; and c) the evaluation of these program activities.

Subjective Measures of Need

Rather than assuming that participants would be interested in programs which address only problem areas that they are experiencing, information as to topic areas of interest was also elicited from the survey. Respondents were asked to indicate how important thirty topic areas are to them. Table 31 presents the frequency distribution of these responses for the thirty topics identified in the survey. The most conclusive information provided by table 31 is that the Wellness Services and Educational Model Program participants are indeed, an extremely varied group, in spite of their age commonality. A substantial percentage indicating that a topic is "not important" is offset in every case by a substantial percentage indicating that the topic is either "very important" or "important" to them. For this reason, the emphasis on breadth rather than depth of services within the Wellness Services and Educational Model Program plan has been a wise approach. The contention on the part of Horowitz that if a topic is presented in depth, many will have no interest and some will lose interest, is substantiated by the survey results. Clearly, covering a wide variety of topics and acting as a referral source for those desiring more comprehensive information is the most effective approach in dealing with such a varied population.

However, the survey results are useful in lending information as to

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prioritizing future activites to reflect the interests of the majority of the participants. The results indicate that social security is most important of the thirty topics identified to the largest percentage of participants (49.2%). Other topics identified as having a great deal of relevance to the participants are high blood pressure (42.0%), home safety (41.7%), highway safety (40.6%), nutrition and diet (39.3%), eye care (37.5%), hearing (37.1%), cancer prevention (37.1%), first-aid/emergency preparedness (36.9%), losing a loved one (34.4%), heart problems (33.6%), community medical services (33.1%), arthritis (33.1%), and insurance (32.0%). The problems which were identified by the highest percentages of respondents as being "not important" to them include human sexuality (63.8%), drug use and abuse (45.3%), and diabetes (40.6%).

To assess the health status of the Wellness Services and Educational Model Program participants, the survey respondents were asked to indicate whether they were bothered by a list of twenty-five health problems "very often", "sometimes", or "not at all". The original list represents a composite of commonly identified health problems of older people that have been identified in the literature. The frequency distribution of the responses is reported in table 32.

As with topic areas of interest, great variability exists among the participants' experiences with health problems. This observation provides further support for the educational approach which emphasizes breadth rahter than depth that is utilized by the Wellness Services and Educational

Model Program. However, selection of, and priority setting among, issues and problem areas to be addressed is essential for planning a responsive and effective human delivery system. To determine the problem areas which are experienced by the greatest number of participants with any frequency, the percentages for the responses "very often" and "sometimes" were combined. In doing so, the problem areas experienced by the largest percentages of participants include eye trouble (53.6%), arthritis (52.3%), nervousness (50.5%), sleeping problems (49.7%), backaches (48.1%), high blood pressure (41.5%), depression (39.3%), coughing (38.9%), headaches (36.0%), obesity (35.9%), shortness of breath (35.9%), and irratibility (33.5%). The problems which the highest percentages of participants indicate that they experience "not at all" include drug problems (72.4%), asthma (71.5%), hay fever (68.0%), being underweight (64.0%), kidney problems (61.1%), rash or skin problems (58.1%), and stomach pains (56.7%). A review of the program calendars from January 1980 through September 1980 indicates that many of the problems which a high percentage of respondents are bothered by at least some time have not been addressed during the six-month period.

Table 31
Frequency Distribution of the Perceived
Relevance of Topic Areas Identified

Topic	Very Important	Important	Not Important
Depression, loneliness	26.5 (120)	20.5 (93)	36.2 (164)
Dealing with retirement	28.3 (128)	26.5 (120)	27.6 (125)
Losing a loved one	34.4 (156)	20.8 (94)	27.4 (124)
Stress, nervousness	20.1 (91)	21.4 (97)	37.7 (171)
Human Sexuality	6.2 (28)	7.7 (35)	63.8 (289)
Tips on Saving Money	26.9 (122)	27.6 (125)	26.9 (122)
Social Security	49.2 (223)	25.2 (114)	11.5 (52)
Insurance	32.0 (145)	25.6 (116)	24.3 (110)
Tax Assistance	26.0 (118)	20.3 (92)	34.0 (154)
Nutrition & Diet	39.3 (178)	27.6 (125)	16.6 (75)
Hearing	37.1 (168)	17.7 (80)	27.4 (124)
Eye Care	37.5 (170)	21.2 (96)	22.3 (101)
First Aid, Dealing with Emergencies	36.9 (167)	26.5 (120)	17.0 (77)
Screening Tests	27.8 (126)	23.2 (105)	25.8 (117)
Community Medical Services	33.1 (150)	26.7 (121)	20.3 (92)
Arthritis	33.1 (150)	23.0 (104)	36.4 (165)
Foot Care	19.6 (89)	23.4 (106)	36.4 (165)
Heart Problems	33.6 (152)	19.9 (90)	26.7 (121)
Lung Problems	19.2 (87)	19.9 (90)	38.9 (176)
Diabetes	20.8 (94)	18.3 (83)	40.6 (184)
High Blood Pressure	43.0 (195)	21.2 (96)	17.0 (77)
Exercise	30.2 (137)	28.9 (131)	22.7 (103)

Table 31 (continued)

Topic	Very Important	Important	Not Important
Recreation	29.4 (133)	28.3 (128)	22.1 (100)
Drug Use and Abuse	17.0 (77)	15.9 (72)	45.3 (205)
Dental Care	21.2 (96)	21.2 (96)	36.0 (163)
Cancer Prevention	37.1 (168)	22.3 (101)	19.0 (86)
Home Safety	41.7 (189)	24.9 (113)	13.2 (60)
Highway Safety	40.6 (184)	23.4 (106)	16.3 (74)
Immunization	30.2 (137)	21.6 (98)	25.6 (116)
Adult Education	22.1 (100)	22.1 (100)	32.9 (149)

Table 32
Frequency Distribution of Health Problems
as Perceived by Respondents

Health Problem	Perceived Bothersomeness of Health Problems		
	Very Often	Sometimes	Not at All
Eye Trouble	14.1 (64)	39.5 (179)	32.0 (145)
Ear Trouble	10.2 (46)	23.6 (107)	49.0 (222)
Tooth or Gum Problems	3.1 (14)	26.9 (122)	49.9 (226)
Shortness of Breath	7.9 (36)	28.0 (127)	46.1 (209)
Pain in Chest	4.4 (20)	22.1 (100)	54.1 (245)
Coughing	7.3 (33)	31.6 (143)	41.7 (189)
High Blood Pressure	15.7 (71)	25.8 (117)	42.4 (192)
Sinus Problems	11.3 (51)	24.1 (109)	45.9 (208)
Asthma	1.3 (6)	4.6 (21)	71.5 (324)

Table 32 (continued)

Health Problem	Very Often	Sometimes	Not at All
Hay Fever	0.9 (4)	7.5 (34)	68.0 (308)
Swollen Joints	6.6 (30)	20.8 (94)	50.8 (230)
Backache	11.9 (54)	36.2 (164)	34.9 (158)
Sleeping Problems	15.7 (71)	34.0 (154)	35.1 (159)
Irritability	3.3 (15)	30.2 (137)	44.8 (203)
Stomach Pains	3.8 (17)	19.0 (86)	56.7 (257)
Kidney Problems	3.8 (17)	13.5 (61)	61.1 (277)
Bladder Problems	6.8 (31)	19.4 (88)	51.7 (234)
Nervousness	14.1 (64)	36.4 (165)	34.2 (155)
Arthritis	23.6 (107)	28.7 (130)	34.0 (154)
Rash or Skin Problems	3.8 (17)	16.3 (74)	58.1 (263)
Depression	6.0 (27)	33.3 (151)	41.1 (186)
Headaches	6.4 (29)	29.6 (134)	44.8 (203)
Drug Problems	0.7 (3)	3.1 (14)	72.4 (328)
Overweight	17.7 (80)	18.5 (84)	43.9 (199)
Underweight	2.6 (12)	5.1 (23)	64.0 (290)

As has been referenced in previous sections of this report, a health status index was derived from the problem identification section, as a way of gaining more programmatic insight as to those who are in relatively poorer health than their contemporaries. It is important to emphasize that comparisons made as to health status are relative to the participant population. As a whole, this group may, for whatever reasons, be healthier (or less healthy) than those elderly county residents who are not attending the Wellness Services and Educational Model Program.

Individuals are identifed as "high risk" if they indicated that they are bothered "very often" by at least five health problem areas and/or are bothered by fourteen or more problem areas "sometimes". "Moderate risk" individuals are those who are bothered by one to four problem areas "very often" and/or five to thirteen problem areas "sometimes". Individuals are identified as being "low risk:, if they indicated that they are bothered by less than four problem areas "sometimes" and/or nineteen or more problem areas "not at all". In doing so, "high risk" individuals comprise 20.13% of the participant population, "moderate risk" comprise 45.80% of the population, and "low risk" represents 34/07% of the participant population.

The health status characteristic is correlated with the age, sex, and living situation of the participant population. Interestingly, as seen in table 33, the health status of the population is inversely associated with age. A higher percentage of respondents under the age of 65 are "high risk" for health problems (45.8%) than is true for those 65 to 69 years of age (14.8%), 70 to 74 years of age (19.8%), 75 to 79 years of age (21.3%), or

over the age of 80 (20.0%). The association is even more dramatic in the "low risk" category: as the age of the participants increase, the percentages of "low risk" individuals also increase. Only 8.3% of those participants under the age of 65 are "low risk" for health problems, compared to 27.3% of those aged 65 to 69, 23.4% of those aged 70 to 74, 41.7% aged 75 to 79, and 40.0% of those over the age of 80.

Table 34 evidences the fact that females are more apt to be "high risk" for health problems (25.0%) than are males (12.7%). As seen in table 35, participants who live with their spouses are less likely to be "high risk" for health problems (16.6%) than are those who live alone (22.4%), or their family (33.3%).

No differences are apparent in the health status of participants attending different sites; nor is the index associated with the educational level of the participants. Of particular interest is the fact that the health status of the participants bears no relationship with the time since last physician visit for either a physical check-up or for treatment of an illness. As discussed in previous sections of the report, the individuals with poorer health problems, as assessed through self-identification of health problems, attended the health fair in higher numbers than did their contemporaries, and also tended to rate the health education and information programs more favorably than did the participants of average to above average health status.

Table 33
Participant Health Status By Age
N=436

Health Status	Age: Less than 65 % (n)	65 - 69 % (n)	70 - 74 % (n)	75 - 79 % (n)	80 Years and Over % (n)
High Risk	45.8 (11)	14.8 (13)	19.8 (23)	21.3 (23)	20.0 (19)
Moderate Risk	45.8 (11)	58.0 (51)	51.7 (60)	37.0 (40)	40.0 (38)
Low Risk	8.4 (2)	27.3 (24)	28.4 (33)	41.7 (45)	40.0 (38)

Chi Square = $p < .05$
Cramer's V = .1821

Table 34
Participant Health Status by Sex
N=437

Health Status	Sex: Male % (n)	Female % (n)
High Risk	12.7 (22)	25.0 (66)
Moderate Risk	51.4 (89)	44.3 (117)
Low Risk	35.8 (62)	30.7 (81)

Chi Square = $p < .01$
Cramer's V = .1498

Table 35
Participant Health Status by Living Situation
N=430

Health Status	Living Situation: Alone % (n)	With Spouse % (n)	With Family % (n)
High Risk	22.4 (53)	16.6 (29)	33.3 (6)
Moderate Risk	42.6 (101)	54.3 (95)	27.8 (5)
Low Risk	35.0 (83)	29.1 (51)	38.9 (7)

Chi Square = $p < .05$
Cramer's V = .1559

Because the great percentage of individuals living in nursing homes in both Wisconsin and the United States as a whole are widows and/or were living alone prior to admittance to a nursing home, the living situation of the participants may be a useful variable to consider when planning programs to address the needs of the elderly. Table 36 demonstrates that the greatest percentage of recipients live alone (52.3%), compared to those living with their spouses (38.6%), with their family (e.g children or siblings) (4.0%), or friends (0.7%). As was discussed in the section regarding program outreach, the fact that a large percentage of the participants live alone speaks favorably for the success on the part of the County Office on Aging in reaching these people, since important goals of the Wellness

Services and Educational Model Program are to decrease social isolation and maximize functional independence.

Table 36
Frequency Distribution of
Participant Living Situation

Living Situation	Percent	(n)
Live Alone	52.3	(237)
Live with Spouse	38.6	(175)
Live with Family (e.g. children or siblings)	4.0	(18)
Live with Friends	0.7	(3)

Another frequently used measure of health status is time since last physician visit. Because absolute measures lend little information as to the interpretation of this data, the normative approach is used to assess health status in this respect. That is, time since last physician visit for the Wellness Services and Education Model Program participants is compared to similar statistics for the elderly population in the northeastern health systems area (which includes Sheboygan County), and to the state elderly population. The comparative approach is deficient in that regional and state statistics represent data obtained for the population aged 45 years and older, while the participant population is aged 60 years and older.

As seen in table 37, it appears that the participant population has a less favorable health status in this respect than does either the northeastern Wisconsin health systems area elderly population, or the state elderly population. A higher percentage of the participant population have not had a routine physical exam in five or more years (23.6%) than is true for the population 45 years and over in the northeastern region (10.8%), or for the state (9.7%). Similarly, fewer have had a routine physical exam within the past year among the participant population (23.1%) than among the regional population aged 45 and over (57.4%), or the state population 45 years and older (61.7%). Since most of the participant population have not had a routine physical exam within the past four years (58.4%) a program focus in the future may be to emphasize the need for annual physical exams.

Similarly, a higher percentage of participants have also not seen a physician due to illness in five or more years (14.1%) than either the regional population aged 45 years and over (5.8%), or the state population aged 45 years and over (5.4%). And fewer have seen a physician for this reason in the past year (31.2%) than have among the regional population who are 45 years and older (50.6%), or the state population aged 45 and over (54.5%). However, while routine physical exams are encouraged among the elderly because they are considered to be a preventive measure, the data presented for time since last physical exam due to illness may indicate that the Wellness Services and Educational Model Program participants are indeed healthier than the elderly population in either the northeastern

region or in the state. Definitive conclusions cannot be made in this regard however, since the fact that the program participants are visiting physicians with relatively low frequency could be attributable to lack of insurance or inadequate finances; lack of transportation; perceived inadequacy of, or mistrust of, the health care delivery system;or lack of knowledge of available services; as well as the possibility that the participant population is relatively healthy and free of illness.

Table 37
Selected Health Status Indicators in the
Survey, Northeastern Region, and State Elderly Population*
(Percent Distribution)

Selected Health Status Indicators	Survey Respondents (Age 60+)	Northeastern Health Systems Area Population (Age 45+)	State Population (Age 45+)
Time Interval Since Last Routine Physical Exam			
Less than 1 year	23.1	57.4	61.7
1 - 2 years	20.3	8.4	7.8
2 - 4 years	15.0	17.6	15.5
5 years or more	23.6	10.8	9.7
Time Interval Since Last Physician Visit Due to Illness			
Less than 6 months	23.0	50.6	54.5
6 - 11 months	8.2	18.4	18.0
1 - 2 years	20.5	9.3	8.9
2 - 4 years	2.2	13.1	10.5
5 years or more	14.1	5.8	5.4

*Source: Southeastern Wisconsin Health Systems Agency, 1977 Wisconsin Health Status Survey, Volume II: Estimates and Estimating Procedures, July 13, 1978.

Objective Measures of Health Status

The subjective measures of the needs, concerns, and health problem areas are useful in evaluating program attempts to date, as well as to prioritize and plan for the future since self-identified interests and problems are those most amenable to intervention. However, perceptions of problem areas lend little information as to the prevalence and/or incidence of problems within a population. For this reason, and also because the program target population includes all county elderly residents, and the survey could only obtain information for elderly persons who attend the Wellness Services and Educational Model Program, objective measures of health status will be presented in this section. Again, need is determined through the use of social indicators; data for the population of interest is compared to state data. The latter represents normative "standards", and need is said to exist within the target population in those contexts falling short of the specified standards. Unfortunately, data are unavailable that apply specifically to the Sheboygan County elderly population, which comprises the target population of the Wellness Services and Educational Model Program. However, data have been obtained which are specific to the northeastern health systems area, which includes Sheboygan County. As was encountered in the previous section, the interpretation drawn from the data is limited in that it pertains to individuals who are 45 years of age and older, while the target population is 60 years and older. There is a great deal of overlap, and therefore, comparability between these age groups; but moreover, the present needs of the individuals between the

ages of 45 and 59 is useful information for program planning, since this population represents potential Wellness Services and Educational Model Program participants.

Table 38 provides evidence that the population aged 45 and over in the northeastern region are less healthy with respect to acute conditions than is true for the similar population in the state, but have a more favorable health status with respect to chronic conditions than is true for this population in the state as a whole. 4.1 percent of the regional population aged 45 and over have acute conditions, compared to only 2.75% of this age group in the state. A breakdown of acute conditions shows the incidence of infective and parsitic diseases, respiratory conditions, and injuries is higher among individuals aged 45 and over in the northeastern region than in the state. However, in reviewing the percentage of the population with limitations of activity due to chronic conditions, the rate for the northeastern region is lower (13.0%) than for the state (16.9%). An analysis of the percentage distributions of specific chronic diseases among persons 45 years and over supports this conclusion, except in the case of diseases of the circulatory system where the percentage is higher among the northeastern regional population aged 45 and over (24.4%) than is true for the similar population in the state (23.9%).

Insurance coverage is a major component in ensuring access to medical care, and is important to consider in assessing the health status of a population. With regards to hospital insurance, this is not a major problem among the population aged 45 and older in the northeastern region, since

95.5% are covered by hospital insurance. However, the percent having health insurance is alarmingly low — 88.6% compared to a state rate of 94.9%. With the availability of Medicaid and Medicare as medical insurance for our eldelry and indigent citizens, it is questionable whether the problem should be of such magnitude in the northeastern region. This information, coupled with the fact that a high percentage of Wellness Services and Educational Model Program participants identified both social security and insurance as high priority issues, may warrant intensified program planning by the County Office on Aging in the area of medical assistance.

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Table 38
Health Statistics of the Population
Aged 45 and Older in the Northeastern Health
Systems Area and in the State
1977 Estimates

Health Status Indicators	Regional Population N=156,767 Percent	State Population N=1,416,678 Percent
All Acute Conditions	4.1	2.75
Infective & Parasitic	***	0.16
Respiratory	2.4	1.41
Digestive	***	0.21
Injuries	1.1	0.96
Chronic Conditions		
Limitations of Activity due to chronic conditions	13.0	16.90
Diabetes	4.8	7.77
Diseased of CNS	2.0	4.60
Circulatory System	24.4	23.90
Respiratory System	2.3	5.45
Urinary System	0.7	1.38
Prostate (male)	***	0.38
Female Problems (excpt breast)	***	0.66
Arthritis & Rheumatism	4.1	13.38
Diseases of Musculo-skeletal System & Connective Tissue	0.6	2.81
Digestive System	1.5	2.92
Malignant Neoplasms	***	1.72

*Source: Southeastern Wisconsin Health Systems Agency, 1977 Wisconsin Health Status Survey, Volume II: Estimates and Estimating Procedures, July 13, 1978.

***Insufficient data for estimation.

PART IV SUMMARY

"Old age can be an emotionally healthy and satisfying time of life with a minimum of physical and mental impairment" according to Robert Butler, M.D. and Myrna Lewis, ACSW, in their book, Aging and Mental Health.[13] This quote serves as a goal for programming at the Sheboygan County Food and Fellowship sites, presenting a challeng to develop a health promotion and disease prevention program which would assist in bringing about this state of well-being for the county elderly population. After nearly two years of operation of the Wellness Services and Educational Model Program, an evaluative study has been useful in illuminating program strengths and weaknesses, and provides empirical evidence to rationalize the process of program development and management in continual pursuit of program goal attainment. Because well-being and functional independence are not static, measurable concepts, the evaluative study largely employs implementation evaluation as a means of measuring effectiveness.

Some problems were encoutered in comparing county demographic variables with participant demographic variables as a way of evaluating the outreach component of the Wellness Services and Educational Model Program. However, the available data provides evidence that the Sheboygan County Office on

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[13] Robert N. Butler and Myrna I. Lewis, Aging and Mental Health (St. Louis: The C.V. Mosby Co., 1977), p. 17, quoted from Ilajean Horowitz, A Health Promotion Disease Prevention Model for the Elderly, (Master's Thesis, UW-Oshkosh, 1980), p. 12.

Aging is reaching an elierly population representing a wide variety of characteristics. Moreover, it appears that in targeting the very old and individuals who live alone, the agency is providing services to individuals most in need. However, there is some indication lack of transportation services may be posing a barrier to service, and that transportationally handicapped individuals are disproportionately excluded from the program participant population. Becuase most of the participants indicated that they learned of the program through family and friends, it is impossible to accurately determine the effectiveness of the outreach methods utilized by the Sheboygan County Office on Aging. There is some indication, however, that newspaper advertising is more effective than the other methods utilized in reaching potential participants.

As predicted by the Director of the Office on Aging, the primary reason people are attending the Wellness Services and Educational Model Program is for the noon-time meal, and then for the opportunity to socialize. Because these two features had already proven to be major attractions for the county nutrition program, the County Office on Aging is able to target a large elderly population with the Wellness Services and Educational Model Program by incorporating it into the nutrition project. A substantial number of individuals also cited the health education and information program, community referral service, and to a lesser degree, the exercise program as one of the three primary reasons for attending the Wellness Services and Educational Model Program.

In general, the health education and information, and nutrition program

components are effective features of the program, and presentations by community professionals have been a particularly strong aspect. This information may encourage the County Office on Aging to continue to solicit assistance by community professionals, in spite of the problems encountered in doing so in the past. The reaction to the health education and information, and nutrition program features are favorable at all eleven sites, but for whatever reasons, all program features are consistently rated lower by the participants at Sheboygan Falls, Adell, Cedar Grove, and Oostburg than at the other seven sites. The life experiences of the participants at these sites could be qualitatively different than those at the others, and this could explain in part, the fact that the Wellness Services and Educational Model Program has been less successful at the four mentioned sites. However, the programming may be weaker at these sites. The Sheboygan County Office on Aging may wish to investigate this situation further, and take measures to strengthen the Wellness Services and Educational Model Program at these sites in the future.

Of all the program features, the exercise program has been the least effective, probably because it requires active, rather than passive, participation to have the intended effects. Perhaps the County Office on Aging could explore alternative ways of stimulating physical activity among the participants other than the daily exercises. In temperate weather, short walks outdoors could be substituted for the exercises, and indoor games when the weather is not pleasant.

The screening services and information programs offered at the annual

health fair were considered to be very helpful and effective by those participants who attended. The greatest weakness of the event appears to be in the ability of the County Office on Aging to stimulate interest in, and attendance of, the health fair, particularly among participants at Random Lake, Cedar Grove, Cascade, and Oostburg. Intensificaiton of outreach, prior health fair promotion at the nutrition sites, media advertisement, and transportation provisions may increase health fair attendance in the future.

The evaluative study substantiates the findings in the literature that elderly persons living alone are particulary vulnerable to physical and mental deterioration, and are most in need of community services to prevent institutionalization. More so than participants living with other people, those who live alone desire the Wellness Services and Educational Model Program be offered more frequently than the present rate. They also tend to have a poorer health status than their contemporaries. Since they clearly comprise the majority of participants the County Office on Aging has been successful in reaching this particulary vulnerable group.

The assessment of need in the evaluative study illuminated a variety of concerns and issues important to the participants, as well as the problems experienced by the participant population. Because of the great variability among these concerns and problems, the County Office on Aging has been wise in their approach to teaching which emphasizes breadth rather than depth. However, the needs assessment may be useful for prioritizing future programs. A great many high priority issues also emerged which the program has not

addressed to date. Economic concerns are of the magnitude as to take priority in planning future programs; the County Office on Aging may wish to investigate the fact that medical insurance coverage is low among the target population, and make attempts to ameliorate the situation.

Emotional and physical health, well-being, and functional independence are not final, static achievements. Rather, they are on-going processes which contribute to one's ability to lead a satisfying life. For this reason, a service provided with intent of maximizing emotional and physical health, well-being, and functional independence among a population group can never claim that the goals have been attained, and the program may therefore be terminated. Rather, program managers must continually reassess program components to determine effectiveness, and reevaluate the needs of the population to assure that program functions have not begun to operate independently of the group it is meant to serve. An evaluation of the Wellness Services and Educational Model Program of Sheboygan County demonstrates the program has been successful in promoting well-being and functional independence among elderly persons in the past, and provides a great deal of information so that program refinement can occur to ensure continual success in promoting these process goals in the future.

Appendix I
The Survey Instrument

FOOD AND FELLOWSHIP SURVEY

THE PURPOSE OF THIS SURVEY IS TO FIND OUT HOW YOU FEEL ABOUT THE FOOD AND FELLOWSHIP PROGRAM. YOUR ANSWERS TO THE FOLLOWING QUESTIONS WILL BE STRICTLY ANONYMOUS (MEANING NO ONE WILL KNOW WHAT YOUR ANSWERS ARE). MANY QUESTIONS WILL DISCUSS TOPICS RELATED TO YOUR HEALTH NEEDS, AND THE INFORAMTION PROGRAMS BEING OFFERED AT YOUR SITE. THE ANSWERS YOU GIVE WILL HELP US TO PLAN FOR THE PROGRAM IN THE FUTURE. PLEASE ANSWER ALL OF THE QUESTIONS, AND THANK YOU.

I. FOOD AND FELLOWSHIP PROGRAM

1. WHICH SITE DO YOU USUALLY ATTEND? _____

2. HOW OFTEN IS THE MEAL PROGRAM OFFERED AT YOUR SITE?
_____ TIMES PER WEEK.

3. HOW OFTEN DO YOU EAT AT THE SITE, ON THE AVERAGE?
_____ TIMES PER WEEK OR
_____ TIMES PER MONTH

4. DO YOU THINK THE MEAL PROGRAM SHOULD BE OFFERED MORE OFTEN AT YOUR SITE?

YES _____ NO _____

IF YES, CHECK WHICH DAYS OF THE WEEK YOU WOULD LIKE TO SEE THE MEAL PROGRAM OFFERED AT YOUR SITE:

MONDAY _____ TUESDAY _____ WEDNESDAY _____
THURSDAY _____ FRIDAY _____ SATURDAY _____
SUNDAY _____

5. HOW DID YOU FIRST HEAR ABOUT THE FOOD AND FELLOWSHIP PROGRAM?

FRIENDS OR FAMILY _____ NEWSPAPER _____
TELEVISION _____ CHURCH _____ RADIO _____
REFERRAL FROM ANOTHER AGENCY _____
A VISIT FROM A STAFF PERSON IN THE FOOD & FELLOWSHIP PROGRAM _____
OTHER _____ (PLEASE SPECIFY) _____

6. HOW DO YOU USUALLY TRAVEL TO AND FROM THE SITE? (CHECK ONE)

OWN CAR _____ RIDE WITH SOMEONE ELSE _____ WALK _____
USE PUBLIC TRANSPORTATION _____ USE THE STAGECOACH _____
OTHER _____ (PLEASE SPECIFY) _____

7. Of the following, which are the three most important reasons for you to visit the site? Put a number "1" to show the most important reason for you, put a number "2" to show the next important reason for you, and put a number "3" by the third most important reason for you to come to the Food and Fellowhip Program.

To learn about other services, events, and classes that may be of interest to me in the community _____

To do the exercises _____

For the health and information program — for instance, having my blood pressure taken regularly, learning about nutrition, or learning about various medical problems _____

To eat the meal _____

To be with friends and other people _____

8. The following list of topics represent many issues which deal with health needs. Respond to the listed topics below by putt'ng a number which most closely indicates how important these topics are to you. Please use the following scale to show your opinion on each topic.

1 = Very Important
2 = Important
3 = Not Important

_____Depression, Loneliness	_____Arthritis
_____Dealing with retirement	_____Footcare
_____Losing a loved one	_____Heart Problems
_____Stress, Nervousness	_____Lung Problems
_____Human Sexuality	_____Diabetes
_____Tips on Saving Money	_____High Blood Pressure
_____Social Security	_____Exercise
_____Insurance	_____Recreation
_____Tax Assistance	_____Drug Use & Abuse
_____Nutrition & Diet	_____Dental Care
_____Hearing	_____Cancer Prevention
_____Eyecare	_____Home Safety
_____First Aid, Dealing with Emergencies	_____Highway Safety
_____Screening Tests	_____Immunization
_____Community Medical Services	_____Adult Education

9. MANY OF THE TOPICS YOU HAVE JUST RESPONDED TO HAVE BEEN PRESENTED IN THE INFORMATION PROGRAM AT YOUR SITE. GENERALLY, DO YOU FIND THE INFORMATION PROGRAM HELPFUL TO YOU?

YES _____ NO _____

10. IN GENERAL, HOW WOULD YOU RATE THE INFORMATION PROGRAMS AT YOUR SITE?

EXCELLENT _____ SATISFACTORY _____ POOR _____

11. WOULD YOU LIKE TO SEE THE INFORMATION PROGRAMS CONTINUED?

YES _____ NO _____

12. IF YOU HAVE FOUND THE INFORMATION PROGRAMS THAT HAVE BEEN PRESENTED AT YOUR SITE TO BE HELPFUL TO YOU, HAVE THERE BEEN ANY WHICH HAVE BEEN ESPECIALLY INTERESTING TO YOU?

YES _____ NO _____

IF YES, PLEASE WRITE DOWN ANY PROGRAMS (EITHER THE TOPIC COVERED OR THE PERSON THAT PRESENTED) THAT HAVE TAKEN PLACE AT YOUR SITE THAT STAND OUT IN YOUR MIND AS BEING REALLY HELPFUL TO YOU:

13. ARE THERE ANY TOPICS OR ISSUES THAT HAVE NOT BEEN DISCUSSED AT YOUR SITE WHICH YOU BELIEVE ARE IMPORTANT AND SHOULD BE ADDED TO THE PROGRAM?

14. DO YOU FIND THE NUTRITION TIPS THAT ARE TALKED ABOUT AT YOUR SITE TO BE USEFUL TO YOU?

YES _____ NO _____

WOULD YOU LIKE TO SEE THE PART OF THE PROGRAM ON NUTRITION TIPS TO CONTINUE IN THE FUTURE?

YES _____ NO _____

15. DO YOU THINK THE EXERCISES THAT THE GROUP DOES REGULARLY ARE USEFUL TO YOU?

YES _____ NO _____

DO YOU THINK THE EXERCISES SHOULD CONTINUE TO BE INCLUDED IN THE PROGRAM IN THE FUTURE?

YES _____ NO _____

16. WE ALL KNOW THAT THERE ARE A VARIETY OF WAYS THAT INFORMATION CAN BE PRESENTED. WE WOULD LIKE TO KNOW WHICH WAYS YOU THINK ARE BEST TO GET AN IDEA ACROSS. RANK THE METHODS LISTED ON THE NEXT PAGE 1 THROUGH 6, USING EACH NUMBER ONCE, TO SHOW HOW EFFECTIVE YOU THINK EACH METHOD IS IN GETTING AN IDEA ACROSS. PUT A 1 BY THE METHOD THAT YOU THINK IS BEST;

16. (CONTINUED FROM PAGE BEFORE)

A 2 BY THE METHOD YOU THINK IS SECOND BEST; A 3 BY METHOD YOU THINK IS THIRD BEST; AND SO ON, WITH A 6 BY THE METHOD YOU THINK IS THE LEAST EFFECTIVE IN GETTING AN IDEA ACROSS:

_____GROUP DISCUSSIONS

_____PROFESSIONAL FROM THE COMMUNITY (SUCH AS NURSES, DENTISTS, TAX SPECIALISTS, ETC) COMING TO THE SITE TO TALK ABOUT ABOUT THE TOPIC

_____QUIZZES AND GAMES RELATED TO THE TOPIC

_____MOVIES

_____SITE STAFF TALKING ABOUT THE TOPIC

_____PAMPHLETS AND READING MATERIALS

B. HEALTH FAIR

17. DID YOU GO TO THE HEALTH FAIR? YES _____ NO _____

18. DID YOU FIND THE HEALTH FAIR AND THE INFORMATION GIVEN OF HELP TO YOU?

YES _____ NO _____ DID NOT ATTEND _____

19. WHAT DID YOU LIKE BEST ABOUT THE HEALTH FAIR? (AGAIN, RANK THE FOLLOWING 1 THROUGH 7 USING EACH NUMBER ONCE; 1 IS THE MOST IMPORTANT, 2 IS THE SECOND MOST IMPORTANT, AND SO ON, WITH 7 BEING THE LEAST IMPORTANT FOR YOU:

_____ENVIRONMENTAL HEALTH INFORMATION

_____PHYSICAL HEALTH INFORMATION

_____MENTAL HEALTH INFORMATION

_____RECREATION/EXERCISES _____DID NOT ATTEND

_____SCREENING & TESTING

_____HEALTH HISTORIES

_____COUNSELING & REFERRALS

C. HEALTH CONCERNS

20. WHEN WAS THE LAST TIME YOU VISITED A PHYSICIAN BECAUSE OF ILLNESS?

_____WEEKS AGO _____MONTHS AGO _____YEARS AGO

21. WHEN WAS THE LAST TIME YOU HAD A COMPLETE PHYSICAL CHECK-UP?

_____WEEKS AGO _____MONTHS AGO _____YEARS AGO

22. CONCERNING YOUR OWN HEALTH CONDITION, CHECK THE RESPONSE THAT SHOWS HOW FREQUENTLY YOU ARE BOTHERED BY EACH OF THE FOLLOWING HEALTH PROBLEMS:

	VERY OFTEN	SOMETIMES	NOT AT ALL
A. EYE TROUBLE	____	____	____
B. EAR TROUBLE	____	____	____
C. TOOTH OR GUM PROBLEMS	____	____	____
D. SHORTNESS OF BREATH	____	____	____
E. PAIN IN CHEST	____	____	____
F. COUGHING	____	____	____
G. HIGH BLOOD PRESSURE	____	____	____
H. SINUS PROBLEMS	____	____	____
I. ASTHMA	____	____	____
J. HAY FEVER	____	____	____
K. SWOLLEN JOINTS	____	____	____
L. BACK ACHE	____	____	____
M. SLEEPING PROBLEMS	____	____	____
N. IRRITABILITY	____	____	____
O. STOMACH PAINS	____	____	____
P. KIDNEY PROBLEMS	____	____	____
Q. BLADDER PROBLEMS	____	____	____
R. NERVOUSNESS	____	____	____
S. ARTHRITIS	____	____	____
T. RASH OR SKIN PROBLEMS	____	____	____
U. DEPRESSION (LOW SPIRITS)	____	____	____
V. HEADACHES	____	____	____
W. DRUG PROBLEMS	____	____	____
X. OVERWEIGHT	____	____	____
Y. UNDERWEIGHT	____	____	____

D. THE FOLLOWING QUESTIONS WILL HELP US RESPOND TO YOUR NEEDS AND WILL ASSIST US IN REVIEWING THE INFORAMATION.

23. HOW OLD ARE YOU? _____

24. WHAT IS YOUR SEX? MALE _____ FEMALE _____

25. WHAT IS, OR IF YOU ARE RETIRED, WHAT WAS YOUR PRIMARY OCCUPATION?

26. ARE YOU PRESENTLY EMPLOYED? YES _____ NO _____

IF YES, CHECK IF YOU WORK FULL TIME OR PART TIME: FULL TIME _____

PART TIME _____

27. PLEASE CIRCLE ONE OF THE FOLLOWING TO SHOW THE LAST YEAR OF EDUCATION THAT YOU HAVE COMPLETED:

1 2 3 4 5 6 7 8 9 10 11 12

1 YEAR COLLEGE 2 YEAR COLLEGE 3 YEARS COLLEGE 4 YEAR COLLEGE

POST-GRADUATE STUDY POST-GRADUATE DEGREE

IF YOU HAVE GRADUATED FROM COLLEGE, PLEASE SPECIFY ANY DEGREES YOU MAY HAVE:

28. OF THE FOLLOWING, CHECK THE RESPONSE WHICH INDICATES YOUR PRESENT LIVING SITUATION:

_____I LIVE ALONE

_____I LIVE WITH MY SPOUSE

_____I LIVE WITH A FAMILY MEMBER, SUCH AS A CHILD

_____I LIVE WITH A FRIEND OR FRIENDS

_____OTHER (PLEASE SPECIFY) _____

PROGRAMS	FREQUENCY	PROVIDER	LOCATION	Comments, Additions Ranking 3 = very important 2 = important 1 = unimportant
BLOOD PRESSURE				
Importance of blood pressure reading	yearly	public health nurse	each site	
Teach self-administered blood pressure reading	quarterly	public health nurse	each site	
Blood pressure monitoring (in conjunction with counseling)	quarterly	public health nurse	each site	
EXERCISE				
Moderate exercises prior to meal-increasing as capability increases	daily	site managers-volunteers training program provided	each site	
Value of exercises	quarterly	M.D. Y.M.C.A. staff	each site	
NUTRITION				
Nutrition Quiz on variety of topics	daily	site manager or volunteers (trained by dietitian)	each site	
Nutrition topic and counseling	bi-monthly	dietitian	each site	
DRUG USE AND ABUSE				
Discussion over the counter, generic, combination of drug use, update prescriptions, alcoholism, over use of drugs	yearly	pharmacist Technical Institute instructors with students	each site	

PROGRAMS	FREQUENCY	PROVIDER	LOCATION	Comments, Additions Ranking 3 - very important 2 - important 1 - unimportant
DENTAL CARE Proper mouth care-teeth, gums, dentures	yearly	dentists dental hygenists dental wives	each site	
ARTHRITIS AND DIABETES Explanation of hospital programs	yearly-ongoing	hospital staff site managers-keep group informed when hospital program is coming up	each site	
MENTAL HEALTH Isolation, withdrawal, loss, depression	yearly	psychiatrist Mental Health Center Mental Health Association	each site	
Stress management	yearly	"	each site	
Death and dying	yearly	"	each site	
Counseling available	as needed	"	each site	
Attitudes toward aging, control over behavior	as needed	"	each site	
FOOT CARE Proper foot care	yearly	podiatrist public health nurse	each site	
Foot clinic	yearly	podiatrist Visiting Nurses Assn.	four sites	

PROGRAMS	FREQUENCY	PROVIDER	LOCATION	Comments, Additions Ranking 3 - very important 2 - important 1 - unimportant
HIGHWAY SAFETY				
Quiz Tips for safe driving speed, safety belts, rules of road, eye tests	monthly	site managers (trained by Highway Safety	each site	
Defensive driving course	yearly	Technical Institute	one site	
EMERGENCY PREPAREDNESS				
Vial of Life	always available	distributed by site manager	each site	
Checklist for emergency	always available	distributed by site manager	each site	
Telephone reassurance	always available	distributed by site manager	each site	
EYE CARE				
Explanation of glaucoma cataracts, need for testing	yearly	ophthalmologist optometrist Technical Institute instructors & students in optical assistant program	each site	
Eye glass repair clinic	yearly	Technical Institute instructor & students	six sites	

PROGRAMS	FREQUENCY	PROVIDER	LOCATION	Comments, Additions Ranking 3 - very important 2 - important 1 - unimportant
CANCER PREVENTION				
breast self-examination	yearly	public health nurse representative from Cancer Society	each site	
Discussion how to prevent cancer, check-up, smoking, warning signals, etc.	yearly	representative from Cancer Society	each site	
Stop smoking self-help group	ongoing	representative from Cancer Society	where 5 or more smokers congregate	
CARDIOVASCULAR SYSTEM AND LUNGS				
Stroke-importance of diet, exercise, etc.	yearly	M.D. respiratory therapist physical therapist	each site	
No smoking (could be incorporated with other areas)				
ENVIRONMENTAL				
Home safety	ongoing	site managers & volunteers at sites	each site	
Water supply Pollution Nuclear concerns	yearly	public health department	each site	
Chore service	ongoing	site manager	each site	
Home care services	ongoing	site manager	each site	
Mobile meals VNA Homemaker	yearly	Visiting Nurses Assn.	each site	

PROGRAMS	FREQUENCY	PROVIDER	LOCATION	Comments, Additions Ranking 3 = very important 2 = important 1 = unimportant
WELLNESS				
Life-styles, attitudes, counseling and appropriate referrals and follow-up	yearly	M.D. public health nurse	each site	
Flu shots	yearly	public health nurse	each site	
SOCIAL SECURITY INSURANCE				
Social Security and Medicare-how to use the system, fill out forms, etc.	bi-monthly	Social Security representative	each site	
Insurance information	yearly	insurance underwriters	each site	
Insurance counseling	ongoing by appointment	insurance underwriters	each site	
LIBRARY AND RECREATION INFORMATION				
Library programs include wellness books & magazine articles	twice monthly	Head Public Library	two sites	
•	monthly	Random Lake & Falls libraries	two sites	
•	monthly	site managers-hand out materials-library's in those areas if possible	seven sites	
Community events	ongoing	site managers	each site	

PROGRAMS	FREQUENCY	PROVIDER	LOCATION	Comments, Additions Ranking 3 - very important 2 - important 1 - unimportant
ECONOMIC CONCERNS				
Financial concerns	yearly	U.W. Extension	each site	
Consumerism	monthly	Technical Institute	each site	
understanding the health industry				
understanding the funeral industry				
how to use the health system				
Employment	yearly	Job Service	each site	
List of employment	ongoing	site managers	each site	
SEXUALITY				
Introduction of subject	yearly	M.D. sex therapist	each site	
HEARING				
Discussion of hearing	yearly	audiologist	each site	

APPENDIX III

ARE YOU GOING TO HAVE THE BLOOD TEST?

IF SO, A COMPLETE MEAL SHOULD BE EATEN 2 HOURS PRIOR TO THE BLOOD TEST.

IF YOU ARE ATTENDING THE HEALTH FAIR IN THE MORNING, EAT:

BREAKFAST

1 cup fruit juice
1 serving cereal with milk & sugar
toast with corn oil margarine & jelly
1 cup low-fat milk

IF YOU ARE ATTENDING THE HEALTH FAIR IN THE AFTERNOON, EAT:

LUNCH

Lean meat (poultry or fish)
Potato or substitute (noodles, rice, etc.)
1 vegetable
Salad and/or fruit
Low-fat dessert
Corn oil margarine
1 cup low-fat milk
Bread

FOODS TO AVOID BEFORE THE BLOOD TEST: BUTTER, EGG YOLK, WHOLE MILK, LIVER, PORK, ICE CREAM.

THE SHEBOYGAN COUNTY HEALTH FAIR IS SPONSORED BY

THE SHEBOYGAN COUNTY OFFICE ON AGING

CONTRIBUTING AGENCIES & GROUPS

AMERICAN CANCER SOCIETY
AMERICAN KIDNEY FOUNDATION
AMERICAN RED CROSS
ANN MC COMIS - VOLUNTEER COORDINATOR
BOY SCOUTS OF AMERICA
CITY OF SHEBOYGAN FALLS
COMMUNITY VOLUNTEERS
LAKESHORE TECHNICAL INSTITUTE
MEAD PUBLIC LIBRARY
MEMORIAL HOSPITAL
MENTAL HEALTH ASSOCIATION
RICHARDSON LUMBER COMPANY
ST. NICHOLAS HOSPITAL
SHEBOYGAN CLINIC
SHEBOYGAN COUNTY COMMISSION ON AGING
SHEBOYGAN COUNTY DENTAL AUXILIARY
SHEBOYGAN COUNTY DENTAL SOCIETY
SHEBOYGAN COUNTY INSURANCE UNDERWRITERS
SHEBOYGAN COUNTY NURSES OFFICE
SHEBOYGAN COUNTY OPTOMETRIC AUXILIARY
SHEBOYGAN COUNTY PHARMACISTS ASSOCIATION
SHEBOYGAN COUNTY PHARMACISTS AUXILIARY
SHEBOYGAN COUNTY PODIATRISTS
SHEBOYGAN COUNTY YMCA
SHEBOYGAN LIONS CLUB
SHEBOYGAN SERVICE CLUB
SHEBOYGAN HEALTH DEPARTMENT
SOCIAL SECURITY ADMINISTRATION
UNIFIED BOARD
UNIVERSITY OF WISCONSIN LABORATORIES
VISITING NURSE ASSOCIATION
WISCONSIN HIGHWAY SAFETY DEPARTMENT
WISCONSIN LUNG ASSOCIATION

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JAN 3 1984

National Institute on Aging

Age Page

Hearing and the Elderly

It is easy to take good hearing for granted. In the world of the hearing impaired, words in a conversation may be misunderstood, musical notes might be missed, and a ringing doorbell may go unanswered. Hearing impairment ranges from difficulty understanding words or hearing certain sounds to total deafness.

Because of fear, misinformation, or vanity, some people will not admit to themselves or anyone else that they have a hearing problem. It has been estimated, however, that approximately 30 percent of adults age 65 through 74 and about 50 percent of those age 75 through 79 suffer some degree of hearing loss. In the United States alone, more than 10 million older people are hearing impaired.

If ignored and untreated, hearing problems can grow worse, hindering communication with others, limiting social activities, and reducing constructive use of leisure time. People with hearing impairments often withdraw socially to avoid the frustration and embarrassment of not being able to understand what is being said. In addition, hearing-impaired people may become suspicious of relatives and friends who "mumble" or "don't speak up."

Hearing loss may cause an older hearing-impaired person to be wrongly labeled as "confused," "unresponsive," or "uncooperative." At times, the feelings of powerlessness and frustration experienced by elderly individuals trying to communicate with others result in depression and withdrawal.

While older people today are, in general, demanding greater satisfaction from life, those with hearing impairments often find the quality of their lives diminished. Fortunately, help is available, in the form of surgery, treatment with medicines, special training, a hearing aid, or an alternate listening device.

Some Common Signs of Hearing Impairment

- Words are difficult to understand.
- Such sounds as the dripping of a faucet or the high notes of a violin cannot be heard.
- A hissing or ringing background noise is heard continually.
- Another person's speech sounds slurred or mumbled.
- Television programs, concerts, and social gatherings are less enjoyable because much goes unheard.

Diagnosis of Hearing Problems

If you are having trouble hearing, see your doctor for treatment or referral to a hearing specialist. By ignoring the problem, you may be overlooking a serious medical condition. Hearing impairments may be caused by: exposure to excessively loud noises over a long period of time, viral infections, vascular incidents (such as heart conditions or stroke), head injuries, certain drugs, tumors, excessive ear wax, heredity, or age-related changes in the ear mechanisms. In view of the importance of good hearing, seeking medical help is certainly worthwhile.

In some cases, the diagnosis and treatment of a hearing problem may take place in the family doctor's office. More complicated cases may require the help of specialists known as *audiologists* or *otolaryngologists*. These specialists are doctors of medicine or doctors of osteopathy with extensive training in ear problems. They will conduct a thorough examination, take a medical history, ask about hearing problems affecting other family members, and order any other necessary laboratory tests. Many times they will then refer the patient to an *audiologist*. Audiologists specialize in the identification, prevention, and management of hearing problems and in the rehabilitation of people with hearing loss. They do not prescribe drugs or perform surgery, but they can recommend and sometimes dispense hearing aids. To test hearing, the audiologist uses an audiometer, a device which electronically generates sounds of different pitches and loudness. The testing is painless and within a short time the degree of hearing impairment can be determined and a course of treatment recommended.

Types of Hearing Loss

Presbycusis (pronounced prez-bee-ku 'sis) is a common type of hearing loss in older people. Changes in the delicate workings of the inner ear lead to difficulties understanding speech, and possibly an intolerance for loud sounds, but not total deafness. Thus, "don't shout—I'm not deaf!" is frequently heard from elderly persons with this type of hearing impairment.

Every year after age 50 we lose some of our hearing ability. The decline is gradual and progressive so that by age 60 or 70 as many as 25 percent of the elderly are noticeably hearing impaired. Just as the graying of hair occurs at different rates, presbycusis develops differently from person to person.

Although presbycusis is usually attributed to aging, it does not affect everyone and some researchers view it as a disease. Environmental noise, certain drugs, improper diet, and genetic makeup may contribute to this disorder. Although the condition is permanent, there is much a person can do to function well despite the impairment.

Conduction deafness is another form of hearing loss sometimes experienced by the elderly. It involves blockage or impairment of the mechanical movement in the outer or middle ear so that sound waves are not able to travel properly through the ear. This may be caused by packed ear wax, extra fluid, abnormal bone growth in the ear, or infection. People with this problem often find that voices and other sounds seem muffled, but their own voices sound louder than normal. As a result, they often speak softly. Depending on the cause, flushing of the ear, medicines, or surgery will prove successful in most cases.

Central deafness is a third type of hearing loss that occurs in the elderly, although it is quite rare even in this age group. It is caused by damage to the nerve centers within the brain. Sound levels are not affected, but understanding of language usually is. The causes include extended illness with a high fever, lengthy exposure to loud noises, use of certain drugs, head injuries, vascular problems, or tumors. Central deafness cannot be treated medically or surgically, but for some, special training by an audiologist or speech therapist can be beneficial.

Treatment

Examination and test results from the family doctor, ear specialist, and/or audiologist will determine the most effective treatment for a specific hearing problem. In some cases, medical treatment such as flushing the ear canal to remove packed ear wax or surgery may restore some or all of hearing ability.

At other times, a hearing aid may be recommended. A hearing aid is a small device

designed to amplify sounds. Although hearing aids are not recommended for all hearing difficulties, some persons can benefit from a properly used device. Before you can buy a hearing aid, you must either obtain a written statement from your doctor (stating that your hearing impairment has been medically evaluated and that you might benefit from a hearing aid) or sign a waiver stating that you do not desire a medical evaluation.

Should a hearing aid be the recommended form of treatment for you, there are several things you should know about buying one. As an informed consumer you should shop for a hearing aid just as for any other product. There are many models on the market, offering different kinds of help for different kinds of problems. Hearing tests can determine the nature of the hearing problem, but only you can judge the comfort, convenience, and quality of sound of an aid. Remember, too, that you are not only buying a product, but a set of services which include any necessary adjustments, counseling in the use of the aid, maintenance, and repairs throughout the warranty period. Before deciding where to buy your aid, consider the quality of service as well as the quality of the merchandise.

When buying a hearing aid keep in mind that the most expensive hearing aid may not be the best for you. You may find one that sells for less and offers you more satisfaction. Buy an aid with only those features you need. Also, be aware that the controls for many of the special features are tiny and may be difficult to adjust. Choose an aid you can operate easily. Many hearing aid dealers (usually called "dispensers") offer a free trial period of up to 30 days so that you may wear the aid before making a decision. It is a good idea to take advantage of the trial period since it often takes at least a month to become comfortable with a new hearing aid. Your dispenser should have the patience and skill to help you through the adjustment period.

At times, people with certain types of hearing impairments may need special training. One form, speech-reading, trains a person to receive visual clues from lip movements as well as facial expressions, body posture and gestures, and the environment. Auditory training may include hearing aid orientation, but it is also designed to help hearing-impaired persons identify their specific communication problems and to better handle them. Although neither speech-reading nor auditory training can improve damaged hearing, they can reduce the handicapping effects of hearing impairment by making the best use of the hearing ability that remains. If needed, counseling is also available so that hearing-impaired elderly are able to maintain a positive self-image while understanding their communication abilities and limitations.

Cost

Because hearing impairments have so many causes, it is important to be examined by your doctor as soon as you suspect a problem with your hearing. Too often, people with hearing problems fail to get medical attention until the condition is beyond help. Unfortunately, the high cost of hearing health care contributes to this neglect. Medicare will pay for the diagnosis and evaluation of hearing loss if requested by a physician, but it will often not pay for the means to correct it. In some states Medicaid covers some costs of a hearing aid. Before buying an aid you may want to contact one of the organizations listed on the back page. Many local chapters are able to provide information concerning Medicaid coverage of hearing aids.

If You Have Problems Hearing

- See your doctor to determine the cause of your hearing problem. Ask if you should see a specialist.
- Don't hesitate to ask people to repeat what they have just said.

- Try to limit background noise (stereo, television, etc.).
- Don't hesitate to tell people that you have a hearing problem and what they can do to make communication easier.

If You Know Someone With a Hearing Problem

- Speak slightly louder than normal. However, shouting will not make the message any clearer, and may sometimes distort it. Speak at your normal rate, but not too rapidly. Do not overarticulate. This distorts the sounds of speech and makes use of visual clues more difficult.
- Speak to the person at a distance of 3 to 6 feet. Position yourself near good light so that your lip movements, facial expressions, and gestures may be seen clearly. Wait until you are visible to the hearing-impaired person before speaking. Avoid chewing, eating, or covering your mouth when speaking.
- Never speak directly into the person's ear. This prevents the listener from making use of visual clues.
- If the listener does not understand what was said, rephrase the idea in short, simple sentences.
- Arrange living rooms or meeting rooms so that no one is more than 6 feet apart and all are completely visible. In meetings or group activities where there is a speaker presenting information, ask the speaker to use the public address system.
- Treat the hearing-impaired person with respect. Include the person in all discussions about him or her. This helps to alleviate the feelings of isolation common in hearing-impaired persons.

For Your Reference

If you would like further information about hearing problems you may contact the organizations listed below. Please be sure to state clearly what type information you would like to receive.

American Academy of Otolaryngologists (Head and Neck Surgery), Inc., 1101 Vermont Ave., N.W., Washington, DC 20005. The Academy is a professional society of medical doctors specializing in diseases of the ear and related areas. They can provide information on hearing and balance disorders.

American Speech-Language-Hearing Association, 10801 Rockville Pike, Dept. AP, Rockville, MD 20852 (or call 1-800-638-8255 for the National Association for Hearing and Speech Action). Either organization can answer questions or mail information on hearing aids or hearing loss and communication problems in the elderly. They can also provide a list of certified audiologists in each state.

Office of Scientific and Health Reports, National Institute of Neurological and Communicative Disorders and Stroke, Bldg. 31, Rm. 8A06, Bethesda, MD 20205. The Institute is the focal point within the Federal government for research on hearing loss and other communication disorders. Ask for the Institute's pamphlet *Hearing Loss: Hope Through Research.*

Self Help for Hard of Hearing People *(Shhh)*, 4848 Battery Lane, Dept. E, Bethesda, MD 20814. *Shhh* is a nationwide organization for the hard of hearing. There national office publishes a bimonthly journal reporting the experiences of those with hearing impairments as well as new developments in the field of hearing loss. A number of publications and reprints are available for the hard of hearing.

September 1983

Andrews proposes health ed

By A.L. MAY
Washington Correspondent

WASHINGTON — Rep. Ike F. Andrews, D-N.C., announced Wednesday his most ambitious legislative initiative in 11 years in Congress — a plan to provide health education to about 9 million elderly Americans who use federally backed senior centers.

In his first-ever news conference in Washington, Andrews called his proposal "a major, major program" that he predicted would be "immensely popular" in Congress.

"Older Americans spend billions of dollars each year for non-prescription remedies — from liver pills to laxatives — when all they really need is proper diet, exercise, rest and information," Andrews said.

Andrews proposes that classes for the elderly be given in senior centers on topics such as diet, illness prevention and the proper use of prescription and non-prescription drugs.

The plan would be put into effect through legislation, introduced by Andrews last month, that would amend the 1965 Older Americans Act. The bill would add health education to the services provided by the $1 billion-a-year program.

About half the money spent today the act goes to operating and providing services at 3,300 senior citizens centers. The centers offer meals, social and legal services, counseling and recreation for the elderly.

The Cary Democrat said that he did not know how much his bill would cost but that the price would be minimized by tapping existing resources, including the senior centers and universities with public health faculties.

Andrews said he hoped to turn the senior centers into teaching laboratories for the nation's 23 graduate-level schools of public health and for hospitals and health professional training centers.

He told reporters his chief worry about the legislation would be resisting efforts to turn his idea into a costly new federal program. "I intend to be diligent in preventing this new program from evolving into another budget buster," he said.

The purpose of the health education, Andrews said, not only is to improve the well-being of the elderly but to reduce the costs to taxpayers of providing health services for the elderly.

He noted that about half the health costs to the federal government, approaching $100 billion a year, were to provide health care to the elderly.

The News and Observer, Raleigh, N. C., Thurs., Dec. 1, 1983 9B

ucation for elderly

Andrews, who has hinted that he might retire from Congress after one more term if he is re-elected next year, said that in his congressional career he had not proposed legislation that was "remotely" as significant as this proposal.

Although he said he hoped the legislation would help his re-election campaign, Andrews said his decision to call attention to the plan was not a campaign strategy.

"It's not just for my race," he said. "If it was, obviously, I would have held this (news conference) in Raleigh."

As chairman of the subcommittee on human resources of the House Education and Labor Committee, Andrews said he planned to hold hearings early next year on the legislation that falls under his subcommittee's jurisdiction.

He said he hoped that at least four regional hearings would be held, including one in Chapel Hill, which is in his district.

Andrews said his proposal had the backing of Dr. Michel A. Ibrahim, dean of the School of Public Health at the University of North Carolina at Chapel Hill, and of the national Association of Schools of Public Health.

Ike F. Andrews

B4 Greensboro News & Record, Sun., Dec. 4, 1983

Andrews proposal would link universities, senior centers

By TIM PITTMAN
Staff Writer

Hoping to encourage better health among older citizens and reduce financial demands on the nation's health-care system, U.S. Rep. Ike Andrews, D-N.C., has introduced a bill that would link the expertise of universities to the more than 3,300 senior citizens centers in the country.

Andrews

"You immediately have 3,320 classrooms to teach health maintenance and illness prevention," Andrews said in a telephone interview last week. "Last year, more than nine million people visited senior citizens centers. You have them as the nucleus for the classroom already."

Andrews said he plans to hold hearings across the country — beginning early next year in Chapel Hill — to shape the program and to gather ideas from administrators and teachers at the nation's 23 schools of public health.

The bill would add health education to the nutrition, social and legal services now offered at senior citizens centers. It would be a part of the Older Americans Act.

Andrews predicted that the program could be put together at a low cost, but he did not know how much.

"We are using the institutions of higher education, particularly schools of public health. Why am I using these? It's money. I don't want this to become a big federal boondoggle where we end up hiring full-time people.

"It will take some money, of course," he said. "But it will be very small. Maybe enough to cover the mileage of university people coming to senior centers, enough for materials in the program. I'm not talking about $150 an hour for a health professional.

"The way I envision it, a faculty member from the school of public health in Chapel Hill would come to Greensboro, for example, and bring five or six students who will be getting course credit," Andrews said. They would determine how many people have various health problems and guide them toward improving their health, he said.

Andrews introduced what he called a "skeletal version" of the bill Nov. 18 that will be amended after hearings across the country.

Dr. Michel A. Ibrahim, dean of the School of Public Health at the University of North Carolina at Chapel Hill, applauded Andrews' proposal.

"It's an excellent idea," Ibrahim said. "The system is already there, and it's well organized for a program such as this. The details have to be worked out, but we are talking about health education and behavior change — better use of drugs, exercise, dietary habits."

Andrews said the bill will help curb the rising financial burden of government-supported medical programs.

"In the opinion of some people, the Medicare program will be insolvent by 1990 unless something is done," Andrews said. "The cost of Medicare next year is estimated to be $50 billion. The next biggest problem is Medicaid, with already $35 billion spent so far this year. About a third of that is for the elderly alone.

"The health care cost for the elderly is approaching $100 billion annually," he said.

Tax your mind. Build your vocabulary. Work Today's Crossword
Greensboro News & Record

Hearing To Air Thoughts On Health Plan

By MIKE McFARLAND
Staff Writer

Local Input Sought

A hearing later this month in Chapel Hill will kick off U.S. Rep. Ike Andrews' (D-N.C.) efforts to get input on a new plan that would provide health education services to the elderly.

Andrews' plan would offer the services to about 9 million elderly Americans who use more than 3,300 federally supported senior citizen centers. The Cary Democrat introduced the plan last month as part of a bill to amend the 1965 Older Americans Act.

The senior citizen centers already offer nutrition, social and legal services as a component of a broader billion-dollar program.

The Dec. 20 hearing in Chapel Hill, part of Andrews' congressional district, is the first of several planned across the country, said Gordon Raley, staff director for the subcommittee on human resources of the House Education and Labor Committee, which is chaired by Andrews.

The hearings will allow input from administrators and teachers in the nation's 23 schools of public health — including the one at the University here — that offer graduate level programs as well as the general public and invited speakers, Raley said from Washington in a telephone interview Tuesday.

"WE'LL BE LOOKING at a lot of aspects of the program," he said. The hearing tentatively has been scheduled to be held in the board room of the UNC General Administration building from 8 a.m. to 5 p.m.

Other hearings will be scheduled in the Washington area and across other regions of the country. The plan, which probably will be revised after the hearings have been completed, could go before the House by May 15, he said.

Andrews believes the plan could turn the senior citizen centers into teaching laboratories for the nation's schools of public health as well as for hospitals and health professional training centers.

Raley said faculty members at the University here, for example, could go to other areas of the state along with students receiving course credit. The faculty and students would help determine the health problems of the elderly at the centers and help them come up with solutions, he said. Those efforts would include providing information about how they could better use prescription and non-prescription medicine, how to exercise more effectively and how to practice better dietary habits.

"We believe they've already got the knowledge," Raley said of the faculty and graduate level students from schools of public health. "They know patients' problems. They really haven't had the place to go out and convey that information on a broad scale."

Michel A. Ibrahim, dean of the UNC School of Public Health, said today he is optimistic about the plan, which he is pledging support for along with the national Association of Schools of Public Health and other organizations.

"I think the idea . . . to provide health education and behavioral change in older citizens' centers is an excellent one," he said. "It deals with measures that are very important to the elderly population. (We) will be pleased to work with (Andrews) to refine the particulars of the bill and make the proposal as effective as possible."

Raley said other school of public health officials had been equally

(Continued on page 8A)

hatever deceives seems to produce a magical enchantment.—Plat

CHAPEL HILL NEWSPAPER

Wednesday, Dec. 7

1-A

...ealth Plan

(Continued from page 1A)

positive about the health education plan.

One of the reasons the new plan is attractive is because it could be put together at a low cost, drawing from already existing sources like the schools of public health, Raley said.

He said the plan could help stop the rising financial burden of medical programs already supported by the federal government.

Thursday, Dec. 8

Andrew's bill aims at improving care for elderly, cutting costs

While it may be a bit premature to start spending the savings, a new bill authored and introduced in Congress by Rep. Ike Andrews, D-N. C., certainly appears to be aimed in the right direction, and could well be one of if not the most significant development in the field of health care for the elderly since the advent of Medicare-Medicaid.

Congressman Andrews' new bill envisions the use of the some 3,300 senior citizen centers across the country to provide health education and information to the nation's some 25 million elderly citizens.

"Older Americans spend billions of dollars each year for non-prescription remedies - from liver pills to laxatives - when all they really need is proper diet, exercise, rest and information," Andrews said.

While the thrust of Andrews' new Health Education for Older Americans bill is to improve the well-being of the elderly, an important side effect, he pointed out, will be a reduction in the cost to the taxpayers in providing health care services to the elderly - thus making it a bill that will also help the dwindling number of taxpayers available to meet ever-rising health care costs.

Congressman Andrews' new bill is one we feel deserves the undivided attention of every member of the Congress, regardless of one's political affiliations.

***

The thing that disturbs me the most about the current conflict between the state Democratic Party and the Helms Re-election Committee is the ever-increasing tendency for Sen. Helms and those affiliated with him to seek to crush, by whatever means available, anyone and everyone who seeks to oppose them, regardless of how many innocent people get run over in the process.

The threat to bring the wrath of the Federal Communications Commission (FCC) down on radio and television stations who dared to air the anti-Helms commercials sponsored by the state Democratic Party was not a threat directed at the Democratic Party, but at the individual station owners, many of whom have been ardent supporters of the Senator in years past.

Many of the state's hundreds of small radio stations and some television stations, too, simply can't afford the threat of going through the expense of a costly and lengthy legal battle with the FCC - a fact that Senator Helms is well aware of.

Neither could these very same stations afford to launch an investigation of the Helms group's allegations, when they refused to point out the so-called inaccuracies - which the Senator was also well aware of.

Anyway you look at it, it's dirty pool and is certainly not appropriate behavior for a United States Senator.

The Franklin Times

according to

asher johnson

***

Terry Kemp, who works for Master Printers, located here in the "Times" building, finally got bro. Fred and me off his back Thursday.

Terry is an ardent deer hunter, but had been scoreless this season up until Thursday, when he bagged a spike, and we have been giving him a hard time about all the other kills, especially those right in his own neighborhood.

I suggested that he simply open the door at his house after that doe got killed crashing into a door at "T" Kemp's house the other afternoon, and maybe one would run right in.

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The News and Observer
December 3, 1983

Health for older Americans

Older Americans have become a vast market for over-the-counter drugs. The elderly spend billions each year on everthing from "liver pills to laxatives," as Rep. Ike Andrews aptly says. And the congressman has hit on an idea that could do the elderly far more good than a regimen of pills — a proper diet, exercise and information.

Andrews has introduced legislation to offer the elderly classes in taking care of themselves. These classes would include not only diet counseling and exercise but also instruction in the proper use of presciption and non-prescription drugs. His idea is to hold such classes at federally supported senior centers, hospitals or universities.

Andrews' plan, which is to be refined in hearings next year, is a welcome response to a large problem. Americans are living longer than their parents and grandparents did. Some 25 million Americans now are 65 or older, and 9 million of those use federally-supported senior centers. But with greater longevity comes the need for greater attention to everyday health — something many older Americans know too little about.

Health care for the elderly now costs the federal government about $60 billion a year, roughly half what the government spends on health care annually. As medical costs rise, preventive health care becomes ever more imporant.

Fortunately, good health can be maintained simply and without excessive cost. But it does require a little education. By introducing his bill and following through on it, Andrews can help make that education available to Americans who would benefit from it.

Nov 12/3/83

Health data needed by elderly, panel told

CHAPEL HILL (UPI) — Systematically delivered health education would help elderly Americans who "often hope for a magic cure" and are frequently "credulous and ill-informed" about health issues and products, health professionals told a House subcommittee Tuesday.

Successful public health measures were largely responsible for the aging of America, and now public health must meet the challenges presented by the nation's 25.5 million citizens over 65 years old, said Dr. Harry T. Phillips, a retired public health professor at the University of North Carolina at Chapel Hill.

Among the challenges health educators face are informing the often susceptible elderly about over medication and telling them of the need for general health maintenance through nutrition and exercise, Phillips said.

"Older people as a group have many aches and pains, often hope for a magic cure or relief of symptoms, are frequently both credulous and ill-informed, and spend more than the average citizen on both prescribed and over-the-counter drugs," Phillips said. "Moreover, the elderly can ill afford wasteful or unnecessary expenditures on medications."

Phillips was one of about a dozen health professionals testifying before the House Subcommittee on Human Resources. The subcommittee is considering a proposal to provide health education to senior citizens by linking university health professionals and the nation's more than 3,300 senior citizen centers.

The proposal, sponsored by subcommittee Chairman Rep. Ike F. Andrews, D-N.C., is offered as an amendment to the Older Americans Act, which offers nutrition, social and legal services to the elderly.

Rep. Carl D. Perkins, D-Ky., chairman of the House Committee on Education and Labor, said the specifics of the bill had yet to be resolved, but he pledged his "whole-hearted support" and predicted it would have an easy time in Congress.

Perkins said the "beauty of this program is that it is going to cost so little money." Andrews, who chaired the hearing, told witnesses repeatedly that he did not want the proposed program to develop into an unwieldy and expensive project.

Dr. Sarah T. Morrow, state secretary of human resources, told the subcommittee that health education should help cut health care costs, which grew 11 percent last year — twice the rate of the rest of the economy.

Health education also should help keep more elderly people in their homes instead of more expensive institutions, she said. Many elderly citizens end up in nursing homes because fewer families take care of them. The government, to contain costs, must take the responsibility for keeping the elderly fit and at home for as long as possible, she said.

"The tradition of families caring for their own elderly is fading fast," Dr. Morrow said. "No longer can we assume that a younger relative is in the home watching out for diet and medication. The trend toward living away from one's family is growing, and it's growing faster in North Carolina than in the rest of the nation."

In North Carolina, the number of elderly living with relatives dropped from 16 percent in 1970 to 10 percent in 1980, Dr. Morrow said. At the same time, the national rate dropped only 2.5 percentage points.

Providing health education to the elderly should involve more than just reaching the estimated 9 million who visit senior citizens' centers, the witnesses said. Larger numbers could be reached by involving retirement communities, churches and local and county health departments, the witnesses said.

State agencies for the elderly also should be involved in planning the program because they can eliminate duplication of services and put instructors in touch with the elderly, said Ernest B. Messer, assistant secretary of human resources and director of the Division of Aging.

Those who take care of the elderly also should be involved, said Richard Anderson, an retired public health professor because Americans are living longer, sons and daughters who are in their 60s often are taking care of parents in their 80s.

"It is the old and decrepit who are taking care of the older and more decrepit," Anderson said.

Staff photo by Jim Stratford

Dr. Michael A. Ibrahim, dean of UNC School of Public Health, speaks to Rep. Ike F. Andrews, center at rear, and others on panel

THE NEWS AND OBSERVER - WED DEC 21, 1983

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DURHAM MORNING HERALD

WEDNESDAY, DECEMBER 21, 1983

Health Program To Aid Elderly

WASHINGTON (AP) — The nation's largest retirees' organization and a health screening group said Tuesday they are launching a program to advise older Americans about how to stay healthy and avoid hospitalization.

The program, called Focus on Health, will begin in February with a series of film strips, tapes, brochures and other materials on cardiovascular health that will be offered at hospitals, nursing homes, schools, senior citizens centers and other sites nationwide.

The American Association of Retired Persons and the National Health Screening Council for Volunteer Organizations will furnish the materials for $1,000 to local sponsoring groups to use during day-long health promotion and education programs.

The two groups, which are both nonprofit, have also lined up nearly $1 million in contributions from drug companies. Programs in May, June, September and October 1984 will focus on mental health, diabetes, arthritis and gastrointestinal disorders, respectively.

The AARP, which has nearly 15 million members, is setting up a $125,000 challenge fund to match up to $250 that any community group raises to present Focus on Health programs.

37-680 O—84——43

Elderly Health Plan Endorsed

By MIKE McFARLAND
Staff Writer

North Carolina health professionals endorsed a proposal from U.S. Rep. Tke Andrews' (D-N.C.) at a hearing here Tuesday designed to get input on a new health plan that would provide health education services to the elderly.

The hearing, conducted by the House of Representatives' education and labor subcommittee on human resources chaired by Andrews, gathered testimony from health professionals, including several Chapel Hillians and University officials.

The bill would amend the 1965 Older Americans Act and increase the services provided by more than 3,300 federally supported senior citizen centers by including health care education. The centers already offer nutrition, and social and legal services.

Stuart Bondurant, dean of the UNC School of Medicine, opened the testimony by saying Andrews' bill "offers immense promise of potential benefit to the health of older Americans by virtue of its sound and appropriate emphasis on health promotion and disease prevention through personal education."

Bondurant also suggested that if passed, the plan should be implemented through pilot projects at senior centers across the nation.

Sarah T. Morrow, secretary of the N.C. Department of Human Resources, testified that she would volunteer North Carolina as a site for a pilot program.

"WE WANT OUR older citizens to be able to spend their years as productive, independent citizens, involved in their community, active both mentally and physically, enjoying their independence with financial security," she said. This means keep[illegible] out of institutions for as lo[illegible] manly possible and helping [illegible] in their own homes. This means teaching them how to live a healthy life. (The bill) would bridge a gap that has too long existed, and fill a need that is vital to the well-being of both our elderly and our economy."

Ernest B. Messer, assistant secretary of the N.C. Department of Human Resource's Division on Aging, said that if the state was to continue to meet the needs of its elderly citizens it would be crucial to care for the elderly at home instead of in nursing homes. The 65 and older

(Continued on page 8A)

Health Plan

(Continued from page 1A)

population is growing faster than any other age group in America, he said, and the number is expected to surpass 1 million in North Carolina by the year 2000. About 5 percent of the elderly are in nursing homes, he said.

The passage of Andrews' bill would give senior citizens a tool to prevent or cope with their health problems, Messer said.

One of the aims of Andrew's bill is to turn the senior citizen centers into teaching laboratories for the nation's 23 graduate level schools of public health as well as for hospitals and health professional training centers.

Michel A. Ibrahim, dean of the UNC School of Public Health, told the subcommitee the bill was a step in the right direction. "There has not been a strong national policy on preventive measures I'm sorry to say — mostly lip service," he said.

FACULTY AND students from schools of public health and other academic centers could provide the information, design and materials for the health education services to the centers, Ibrahim said. The schools also could help determine the effectiveness of the program once it began, he said.

Harry T. Phillips, a recently retired professor from the UNC School of Public Health, told the subcommittee that misuse of medication among the elderly is a problem.

"Older people as a group have many aches and pains, often hope for magic cures or relief of symptoms, are frequently both credulous and ill-informed and spend more than the average citizen on both prescribed and over-the-counter drugs," he said.

Andrews said his proposal, which was introduced in the House in November and referred to the subcommitee, was in skeletal form now. The hearing in Chapel Hill and others scheduled across the nation will help shape the bill into effective legislation, he said.

"What I intended is no more than a vague reference to an idea," Andrews said. "I think it's a good idea . . . I'm quite open-minded and thinking very generally about a concept. We have not formalized any of the particulars."

Rep. Carl Perkins (D-Ky), chairman of the House Committee on Education and Labor, told those testifying that the best thing about the proposal is that it would not cost much to put in place.

Perkins predicted Andrews' bill would be passed by the House with little opposition.

Others offering supportive testimony Tuesday included Harvey Cohen, director of the Center for the Study of Aging and Human Development at Duke University's Medical Center; John T. Denning, vice president of the American Association of Retired Persons; Carolyn Capowski, a faculty member at the UNC School of Pharmacy; Marian K. Solleder, assistant dean of the School of Health, Physical Education, Recreation and Dance at UNC-Greensboro; Richmond Anderson, a former professor in the UNC School of Publich Health; and William C. Byrd, a professor of community health and East Carolina University's School of Allied Health and Social Work.

Chapel Hill Newspaper
December 22, 1983

Less Health Care Only Way to Cut Costs, Study Says

By Spencer Rich
Washington Post Staff Writer

A new Brookings Institution report says that any measurable reduction in the growing cost of health services can be accomplished only by rationing medical benefits.

In "The Painful Prescription—Rationing Hospital Care," Brookings economist Henry J. Aaron and Tufts University medical professor William B. Schwartz say that better management, elimination of duplicate facilities and shifting more care to the outpatient sector will "not save much." Only a cut in benefits will, they say.

The nation's medical bill now accounts for one-tenth of the gross national product.

"Any appreciable restraint on expenditures will be accomplished only at the price of denying medical benefits," the authors predict.

Looking for clues at the British health system, which spends about half as much per capita for hospital care as the United States' does, they conclude that big U.S. savings will come from severe restrictions on spending for things like artificial hearts, liver transplants, intensive care for terminal patients (according to government figures, 28 percent of Medicare money is spent on people in their last year of life), diagnostic X-rays and lab tests, exotic new treatments for some diseases, and expensive new machinery such as successors to the CAT scanner.

Aaron said established services in the United States, such as kidney dialysis and transplants, that clearly have a life-giving capacity, are unlikely to be cut back much; it will be much easier to avert major use of the next generation of services and machines.

One exception to this general rule may be X-rays and lab tests, he said, because the value of the large number of extra X-rays and tests given in the United States as compared with Britain is subject to challenge.

The authors compared British and American practices in a number of areas to see where the British save money by using less. After adjusting for population differences, they found that the British:

- Use three types of treatment as much as U.S. doctors do: high-voltage radiotherapy, hemophilia treatments and bone marrow transplants.
- Use half as many X-rays and half as many films per X-ray examination as U.S. doctors do.
- Use kidney dialysis and transplants about a third as often as U.S. doctors; patients over 55 rarely are given dialysis. They are not told that it is too costly and therefore that they must die, but usually that the treatment is inappropriate for them.

The doctor judges inappropriateness because he knows that facilities are limited. In the United States, Medicare pays for dialysis and transplants, and they are widely used for patients of all ages.

- Use CAT scanners about one-sixth as much; many hospitals don't even have them.
- Have one-tenth to one-fifth as many intensive-care beds, relative to population. This reflects, in part, the British practice of not trying to keep terminal patients alive through heroic medical measures.
- Perform coronary artery surgery one-tenth as much.
- Use chemotherapy on tumors much less than in the United States in cases where its impact is known to be marginal.

The authors say that the U.S. crunch, when it comes, will not necessarily follow the British pattern on any given item. But the overall practice of far less spending on many things that now are provided as a matter of course here, will gradually become the rule.

And there may be a tendency to divert resources from some groups—such as curbing intensive care for terminal patients, many of whom are elderly—to others who would benefit less marginally, Aaron and Schwartz say.

This could lead to political conflict and malpractice litigation, the authors say, but in the end, a concept long accepted by the military and its doctors would come to the fore: "When resources are too few to take care of all the wounded, care is provided to those who stand to benefit the most."

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VOL. XXV, NO. 2 WASHINGTON, D.C. FEBRUARY, 1984

Comprehensive 'Focus on Health' To Blanket Nation's Communities

The Association's health care reform campaign is coming to the nation's communities in a big way.

Beginning this month with the topic of cardiovascular health, AARP and the National Health Screening Council for Volunteer Organizations (NHSCVO) will sponsor a year-long Focus on Health program series which is expected to reach up to one million elderly persons at 600-plus sites around the country.

Corporate sponsorship of the materials and delivery of monthly programs is already approaching $1 million, according to Dr. John Brensike, head of NHSCVO, and the Association has allocated $125,000 for use as matching funds when community groups are unable to raise the basic $1,000 program fee on their own.

(See related column, photo on Page 13)

Designed for persons aged 50 and older, Focus on Health will cover selected health problems during "target" months to increase awareness of health risks, preventive measures, health care alternatives and the normal aging process through audiovisual presentations, one-on-one talks with health experts, demonstrations of medical technology, group discussions, health screening tests, etc.

In explaining the project, Association Executive Director Cyril F. Brickfield said, "We feel health promotion and health screening are fundamental to health care reform. Unhealthy persons make four times as many demands on our health care system as do healthy persons."

Dr. Brensike said of Focus on Health's potential: "I think it is quite possible we'll see hospitals and physicians referring patients to these events because they provide the best possible information."

"We eventually want to reach all ages with this type of help," said Melanie Wieland, NHSCVO's director of research and development. "But we felt we needed to begin with older Americans to dispel myths such as 'they can't do much for themselves,' and 'it's too late'."

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VOL. XXV, NO. 2 WASHINGTON, D.C. FEBRUARY, 1984

The new nationwide Focus on Health programs were formally initiated recently when Dr. Robert Brenske (left), head of the National Health Screening Community Volunteer Organization, and Association Executive Director Cyril F. Brickfield signed papers agreeing to co-sponsorship of the project.

Executive Director's Report

By CYRIL F. BRICKFIELD

While the immediate thrust of our Association's health care reform campaign must be aimed at saving the Medicare program from insolvency and reducing skyrocketing health care costs, we also believe that health education and promotion activities are important if we are to bring about the necessary restructuring of the nation's health care system.

Thus, we are beginning a year-long nationwide health promotion and education program this month which will help thousands of older persons learn more about their health so that they can lead more active, vital lives.

The program is called Focus on Health. It is being co-sponsored by AARP and the National Health Screening Council for Volunteer Organizations (NHSCVO), the organization perhaps best known for developing Health Fair programs throughout the nation. It is expected to reach more than one million persons at 600 program sites this year.

Focus on Health is designed to increase awareness among persons age 50 and older of health risks, preventive measures, health care alternatives and the normal aging process. It seeks to motivate individuals to take an active role in maintaining their health; to educate them about existing community health care resources; and to teach them to be more cost-conscious when selecting health care services.

Each month's program will feature a health topic of concern to older persons. February's topic, for example, is cardiovascular health; May's will be mental health; June's will be diabetes; September's will be arthritis; and October's will be gastro-intestinal disorders. Persons attending this month's Focus on Health programs will receive information on the different types of heart disease, risk factors, prevention, appropriate self-monitoring and self-care measures, the latest medical technology and available community resources.

Each program will take place on a single day. Individuals will be encouraged to learn by *actively participating* in the program. They will have opportunities to hear and talk to health care professionals; view a film on the featured topic; observe demonstrations of the latest relevant medical technology; obtain health screening services; and take part in group discussions, computerized quizzes, etc.

AARP chapters and RTA units can become involved in local Focus on Health programs either as sole sponsors or in cooperation with other community groups. Chapters and units may provide volunteers to assist in planning, publicizing and obtaining funds for and implementing local programs.

NHSCVO, an acknowledged expert in marshaling community resources to provide health promotion services, will utilize its national network of project directors to offer orientation and technical assistance to local organizations sponsoring Focus on Health programs.

In order to underwrite the extensive costs of developing each program, national corporations with an interest in supporting individual topical components will be sought as potential funding sponsors.

It is most appropriate that we begin Focus on Health during our Association's 25th anniversary. It exemplifies our motto: "To serve, not to be served."

House Study Finds Con Men Making a Killing on Quack Cures

By Spencer Rich
Washington Post Staff Writer

Medical con men and others are [illegible] the ill and aged of at least [illegible] a year for unproven or [illegible], some of which not only [illegible] existing conditions but [illegible] accelerate blindness, cancer, [illegible], heart palpitations, in[illegible] and even death, accord[illegible] a four-year study [illegible] a House [illegible]mittee.

[illegible] Claude Pepper (D-Fla.), [illegible] of the health subcommit[illegible] Select Committee on Ag[illegible] said quack remedies found by [illegible] include "moon dust" for [illegible] cancer medicine composed [illegible] human urine and fecal mat[illegible] serums contain[illegible] extracts, amino acids or [illegible] chemicals.

[illegible] remedy for aging in[illegible] raw human organs.

Snake Meat, Horse Warts, Moon Dust and Mistletoe

"Over 75 percent of the products reviewed by the committee were found to be dangerous or potentially harmful," Pepper said. Others have no proven value established by scientific methods.

The report, which will be followed by subcommittee hearings, said that in 1965 the Senate Special Committee on Aging estimated medical fraud at $1 billion to $2 billion a year, but today the figure is at least $10 billion, and some experts believe that it is more than double that amount.

The report said efforts to crack down on the fraud "are almost nonexistent. Only the U.S. Postal Service, which is greatly overworked and undermanned, has anything like a reasonable enforcement under way."

The subcommittee said "phony cancer cures constitute the largest share of such frauds," accounting for $4 billion to $5 billion a year.

"Questionable arthritis cures now cost the nation $2 billion a year," and products purporting to retard or reverse aging cost about the same, it said.

The panel cited as examples of unproven or questionable cancer cures: eating grapes, ground diamonds, ground horse warts in sour milk, mistletoe, Easter lily juice, snake meat, mold and sunflower seeds.

Coffee enemas and serums from goat intestines and fecal matter also were cited. Questionable arthritis remedies included cocaine and Novocain; pills made from male or female sex hormones; bee, snake and ant venom; diets of honey and vinegar or green-lipped mussel extract; various plants and roots, often in tea form, such as ginseng, aloe vera, yucca and alfalfa; acupuncture; exposure to radiation in uranium mines, cow-manure poultices and "moon dust," which the subcommittee said is just sand.

"Theory 'youth cures' constitute the fastest growing and maybe the most profitable of questionable medical remedies," the panel reported. It said questionable products included worthless pills, an instant facelift (which turned out to be a page of facial exercises), pills containing only caffeine, advice to rub castor oil on the skin and prostate cures that consist of sitting on a hot light bulb.

Other remedies for various conditions involved rubbing a frog fried in lard on an area affected by arthritis and "incantations on the moon."

The panel called for harsher penalties for committing fraud, increased funding and powers for the Postal Service to move against quackery, stepped-up efforts by the Federal Trade Commission and the Food and Drug Administration, plus tougher state laws and enforcement efforts.

The FDA and the Council of Better Business Bureaus yesterday opened a joint campaign aimed at curbing misleading advertising for fraudulent medical products, mailing an eight-page information sheet to almost 10,000 ad managers for newspapers and magazines.

REP. CLAUDE PEPPER
... many products "potentially harmful"

Nutrition for Older Americans*

S. Jaime Rozovski, Ph.D.**

When we consider the number of older Americans, it is amazing that we have such limited knowledge of their nutrition needs. Most of the nutrient allowances recommended for people over 65 are projected from the needs of young adults. Fortunately, many groups are now studying how aging affects the way in which our bodies use different nutrients.

Physiological Changes During Aging

As we age, several changes take place in our body that are important from the nutritional point of view. For instance, the total amount of muscle decreases, suggesting that older people may actually require less protein in their diet than young people.

The proportion of total fat in our body increases with aging, but this also may be due, in part, to a more sedentary lifestyle as we get older. As a matter of fact, the actual Recommended Dietary Allowances of the Food and Nutrition Board of the National Academy of Sciences (henceforth called RDA) indicates that elderly people should reduce their calorie intake, so that they can avoid obesity.

The chances of breaking a bone likewise increase. This is due to a loss of bone minerals with aging, which reduces the resistance of bone to fractures. It is estimated that at least 10 percent of the population over age 50 suffer from some degree of bone fracture. Because of the lack of bone mineral, the healing of these fractures is difficult and takes a very long time. The extreme result of bone loss is osteoporosis, a disease characterized by bone loss and present mainly in women.

Of all the changes that occur during aging probably those taking place in the digestive system are the most important from the nutritional point of view.

Aging causes a tendency for the alveolar bone (from the upper and lower jaw) to

**Dr. Rozovski is Assistant Professor of Public Health at the Institute of Human Nutrition, Columbia University.

N. 2119

become loose. This process of periodontal bone loss has been estimated to affect 80 percent of the adult population in the U.S. As a result, 50 percent of the population over 60 have lost their teeth. The end result of this is obvious: older people tend to choose foods that are easy to chew; they thus unconsciously restrict certain nutrients from their diet. An example of this is the limited consumption of foods that are high in fiber because older people find them hard to chew. Yet, there are many soft foods that contain a reasonable amount of fiber which can be substituted. (See Table I)

Another problem is a decrease in the sense of taste as we age. Salty and sweet taste sensations can decline markedly with age. As a result, older people often prefer foods that are richly seasoned. Unfortunately this may result in a high use of salt, an element that, in most cases, should be restricted.

Although it is often thought that old people produce less saliva, this is, actually, not totally clear. If it happens, though, less saliva combined with the presence of poor dentures, can cause great difficulty with dry foods. The problem can be solved by consuming moistened and softened food, or in some cases by dividing food into smaller pieces.

A decrease in the secretion of gastric acid (hydrochloric acid) also occurs with aging. This may seem surprising since so many older people complain of heartburn. However, the heartburn is often caused by other factors such as gas production, rather than by increased acidity.

The reduced ability of the intestine to move its contents through the digestion tract sometimes results in digestive difficulties with certain foods. Some older people may suffer from cramps and diarrhea after eating dairy foods. This occurs because the activity of the intestinal enzyme lactase is reduced, (a condition known as "lactose intolerance"). This enzyme is responsible for the digestion of lactose, the principal sugar in dairy products.

Changes in the gastrointestinal tract that occur with aging result in a reduction of intestinal absorption of some nutrients, including proteins, carbohydrates, fats, and some vitamins and minerals. However, the information now available is not conclusive and it is too early to recommend making marked changes in menu planning because of it. Nevertheless, this is a potential problem which deserves more research in the future.

The Relationship of Aging to Specific Nutrients

Proteins

When we are between 30 and 40 years of age the amount of total protein in our body starts to decline. This decrease is more pronounced in men than women, and is usually "balanced" by an increase in total body fat.

At present there is considerable controversy about the protein requirements of the elderly. Our advice is to keep your protein intake at the same level as that for other adults. The recommended allowance is currently 0.8 grams[1] of protein per kilogram of body weight per day. The protein should be of good quality so that all the required amino acids are provided. In order to limit the amount of saturated fat in your diet, however, you should reduce the amount of red meat and unskimmed dairy products that you eat.

We do not recommend consuming more protein than the allowance described above because recent studies indicate that eating more protein increases the excretion of calcium in the urine. These studies are not conclusive but until more information is available it is advisable to keep your protein intake at the RDA levels since loss of calcium may contribute to increased bone loss.

Carbohydrates

Carbohydrates supply the most energy in our diets. They are consumed in two forms, as

[1] *28 grams is equal to 1 ounce.*

simple sugars and as complex carbohydrates. The complex carbohydrates are divided into those which can be broken down and used by the body and are a source of calories, such as starch, and those which are not broken down and therefore are excreted in the stools. This latter group falls in the category we classify as fiber.

Simple sugars are a pleasant source of low-bulk calories so they should be consumed with caution and in moderation. If most of our calorie needs are filled by these sugars it will affect the intake of other nutrients which are usually absent in simple sugars. On the other hand, the complex carbohydrates (starches) found in potatoes or grains such as wheat, corn, and rice, do contain other essential nutrients. Hence, while these foods add calories they also help to provide needed vitamins, minerals, and fiber. It is recommended that 55 percent of your calories come from carbohydrates, mostly in the form of fiber, unrefined starches, and whole grain or enriched flour.

Fiber

Fiber is referred to as "crude fiber" or "dietary fiber complex."

The average amount of fiber eaten in the United States has decreased in the last century, because we are eating fewer fiber-containing cereals and grains. The end result is that foods containing fiber in this country represent about 35 percent of the calories we consume while in developing countries it amounts to 80 percent.

The more fiber we eat the faster stools pass through our body. This indicates that fiber may have a beneficial effect in chronic constipation.

A series of diseases have been claimed to be due to or aggravated by the reduced amount of fiber in our diet. These include diverticular disease of the colon. "Westernized" countries show a higher incidence of this disease than developing countries. Coarse bran seems to alleviate the symptoms of the disease. Another disease with a higher incidence in developed countries is cancer of the colon. Although fiber may not be related directly to this disease in a causal way, it is probably indirectly related because stools take longer to pass through our intestines. The slow passage of stools through the colon may allow bacteria to act on the stool or its bile acids and produce cancer-causing substances that attack the intestinal mucosa.

Another disease that may be related to low fiber intake is coronary heart disease. Some information suggests that fiber can be effective in lowering cholesteral levels. However, the results are not conclusive.

While the evidence is circumstantial that low fiber diets contribute to a high incidence of diabetes, recent evidence suggests that an increase in dietary fiber may help to manage diabetes.

Several recent studies have shown that adding fiber (20 grams of crude fiber) to the diets of diabetic patients, reduced their blood sugar and reduced the amount of insulin that was necessary to maintain good control.

Added fiber in the diet results in a slower and more sustained release of glucose from the gastrointestinal tract into the blood stream.

Based on the information mentioned above it is recommended that you increase your fiber

Table I. Fiber Content of Some Soft Foods

	Grams of Fiber
Fruits	
Bananas (1 medium)	0.9
Strawberries, raw (½ cup)	1.0
Vegetables	
Broccoli, cooked (½ cup)	1.2
Carrots, cooked (½ cup)	0.7
Mushrooms (10 small)	0.8
Peas, cooked (½ cup)	0.5
Potatoes, mashed (½ cup)	0.4
Spinach, cooked (½ cup)	0.5
Tomato (1 medium)	0.8

intake to approximately 10 grams per day. This doesn't need to be done with foods that are hard to chew since it can be accomplished with soft foods. Table I lists a number of soft foods and the number of grams which are contained in each serving.

Fats

Fat is the most concentrated form of calories in our diet. This is why the best way for you to reduce the intake of calories is to lower the total quantity of fat in your diet. This will have the added benefit of helping you to lower your serum lipid levels and thereby reduce the risk of coronary artery disease. It may also even reduce the incidence of colon cancer, a major cause of death in older people. It is recommended that you consume no more than 30 percent of your calories as fat. If you have high levels of serum cholesterol, we recommend substituting unsaturated for saturated fat.

Calories

There is good evidence as well as good theoretical grounds for recommending that older people consume fewer calories. First, older people are generally less active and hence expend less energy. This is particularly important when an individual leaves a relatively active job for the more sedentary life of retirement. This caloric restriction may be lessened somewhat by keeping active in later life. For this reason we strongly recommend regular forms of moderate exercise, such as walking and swimming. Secondly, there are changes in the body's metabolism which cause it to require less energy. Thirdly, older individuals tend to lose lean body mass, mostly due to some wasting of muscle. This results in an increase in the ratio of fat tissue to lean tissue, or a relative obesity; another good reason for consuming fewer calories.

Since there are other nutrients which should not be reduced and some which should actually be increased, the number of calories you consume requires a certain amount of discretion in the kinds of food that you chose.

Calcium and Phosphorus

The amount of calcium absorbed by our body is governed to some extent by the body's

Table II. Nutrient Recommendations for the Elderly

Nutrient	*Men*	*Women*
Calories	2300/day	2000/day
Protein	56 gms/day	45 gms/day
Fat	25-30% of total daily calories (64-76 gms/day)	23-30% of total daily calories (55-66 gms/day)
Carbohydrates	55-60% of total daily calories (310-345 gms/day)	55-60% of total daily calories (275-300 gms/day)
Fiber	Increase to approx. 10 grams	Increase to approx. 10 grams
Vitamins	Increase B_{12} to greater than 3 mcg	Increase B_{12} to greater than 3 mcg
Calcium	1000 mg/day	1000 mg/day
Phosphorus	Reduce	Reduce
Iron	18-40 mg/day	18-40 mg/day

needs and to some extent by the amount and form of calcium in our diet. Most older individuals lose more calcium than they absorb. This results in a slow but progressive loss of calcium from the bones, its main storage site. Reversing this process is not simply a matter of consuming more calcium. To be effective, calcium must be increased but the phosphorus and protein intake (if very high), must be decreased. The American diet is high in both phosphorus and protein. A typical intake of protein in the form of meats, poultry, fish and dairy products is twice the amount recommended by the National Academy of Sciences in the 1980 *Recommended Dietary Allowances*. Therefore, a slight reduction would still be within the range of adequate protein consumption.

To promote optimal calcium absorption, we must reduce our intake of these two nutrients as well as increasing our intake of calcium. The major sources of phosphorus are meats and carbonated soft drinks (containing phosphoric acid). Thus, we recommend that you consume around one gram of calcium per day, eliminate phosphate-containing beverages and slightly reduce your protein intake.

Iron

Iron is converted from its non-absorbable to its absorbable form by the action of hydrochloric acid in the stomach. As mentioned above, many older individuals secrete less hydrochloric acid than normal and hence may be absorbing iron poorly.

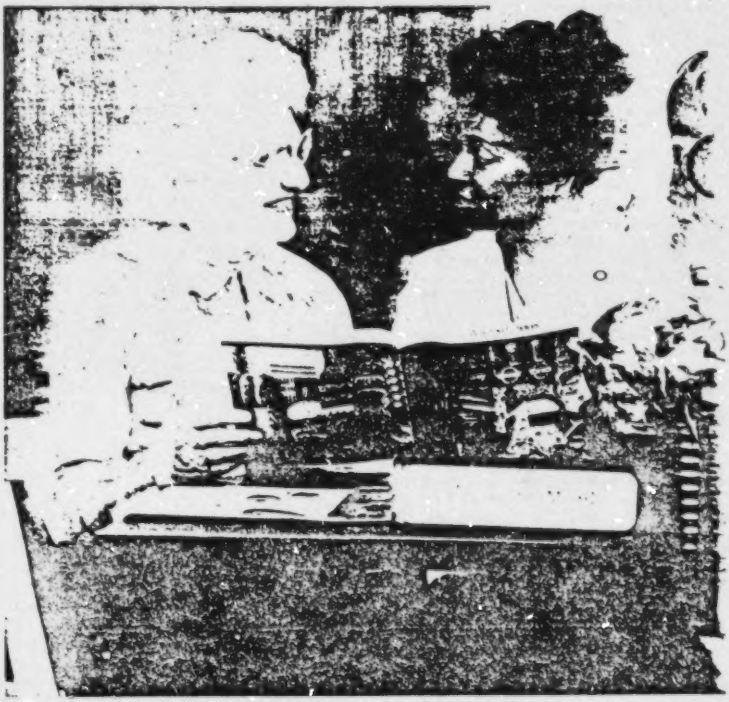
We recommend taking 18 mg of iron daily in the ferrous (absorbable) form. The best way to insure this amount without consuming too much red meat or organ meat is to use fortified foods, particularly cereals. (Avoid sugared cereals, however.) If this cannot be done, you can supplement iron in the form of tablets or drops.

Vitamins

We know almost nothing about the actual vitamin requirements of older people. There are certain theoretical arguments for an overall reduction in B vitamin requirements since caloric needs are reduced and the requirements of the B vitamins are dependent on the amount of calories consumed. On the other hand, there are other arguments which make a good case for an increased requirement for these vitamins since certain organs, such as the nervous system, may not be functioning optimally and most of these vitamins exert their major biochemical effects on the nervous system. Thus, at the present time, we would recommend a balanced diet rich in whole grains and low-fat dairy products and would not recommend direct supplementation.

Table III. Sample Menu

BREAKFAST	Tea or coffee Toast with soft margarine Banana slices Cooked whole wheat cereal Low-fat milk Orange juice
MID-MORNING	Pear
LUNCH	Broiled chicken Spinach Baked potato Whole wheat bread Soft margarine Low-fat milk Coffee or tea
EVENING	Cream of tomato soup (made from low-fat milk) Tossed salad Whole grain bread Soft margarine Baked apple Tea or coffee
EVENING SNACK	Fruit cake Low-fat milk Tea or coffee



There is one vitamin, B_{12}, which must be combined in the stomach with a substance known as the "intrinsic factor" in order to be properly absorbed in the intestine. Older people may be deficient in the intrinsic factor and vitamin B_{12} absorption may therefore be poor. Vitamin B_{12} is present in all meats (and foods of animal origin) and hence on a varied diet no problems should develop. If you are mainly following a vegetarian diet, however, supplementation is recommended.

Table II summarizes the recommendations outlined above. These recommendations may need to be changed as new information is gathered, but we feel that, at present, it can serve as a guide to proper nutrition for older people. Table III indicates a sample menu for an 1800-2000 calorie per day diet with the nutrient specifications that are discussed above.

Iron Sources
(Each portion provides approximately 6 mg iron)

Food	*Weight*	*Serving*
Calves liver	42 grams	1½ oz.
Beef liver	70 grams	2½ oz.
Chicken liver	70 grams	2½ oz.
Chicken (fresh only)	364 grams	13 oz.
Beef (lean only)	168 grams	6 oz.
Sardines, Atlantic	168 grams	6 oz.
Pork, loin (lean only)	170 grams	6 oz.
Whole wheat bread (soft & firm crumb)	196 grams	7 slices
White bread (soft crumb)	280 grams	10 slices
White bread (firm crumb)	243 grams	9 slices
Beans, lima, cooked	238 grams	1-1/3 cups
Beans, kidney, cooked	240 grams	1-1/4 cups
Tofu (soybean curd)	360 grams	2½ pieces

Distribution of Fats in Common Foods

High in Polyunsaturated Fats	*Moderately High in Polyunsaturated Fats*	*High in Monounsaturated Fats*	*High in Saturated Fats*	*High in Cholesterol*
Safflower oil	Soybean oil	Peanut oil	Meats high in fat: sausages, cold cuts, prime cuts, etc.	Egg Yolks
Corn oil	Cottonseed oil	Peanuts & peanut butter	Chicken fat	Liver
Soft margarine: made of corn oil	Other soft margarines	Olive oil	Meat drippings	Kidney
Walnuts	Commercial salad dressings	Olives	Lard	Sweetbreads
Soybeans	Mayonnaise	Almonds	Hydrogenated shortening	Brains
Sunflower seeds		Pecans	Stick margarines	Heart
Sesame seeds		Cashews	Coconut oil	Pate'
Oils made from these seeds		Brazil nuts	Butter & products with dairy fat, e.g. cheese, cream, whole milk, ice cream, chocolate bakery items	Caviar
		Avocados		Dairy fats
				Products made with the above, e.g. cakes, pies, pastries, gravies, etc.

Drug-Nutrient Interaction

The interaction between drugs and nutrients has received increasing attention during the last decade. The use of drugs in our society for the treatment of specific diseases and for the relief of perceived ailments has reached unprecedented levels. Because of their high consumption of medications, the elderly are particularly at risk for drug-induced nutrient deficiencies. There are several ways in which drugs can interact with nutrients: they can increase the excretion of the nutrient; they can increase the utilization of the nutrient; and they can compete with the nutrient at the site of action. Table IV lists a series of drugs, some of which are commonly taken by the elderly, that can cause alterations in nutrient metabolism. A more detailed analysis of the most commonly used drugs follows.

Aspirin

Aspirin in one form or another is perhaps the most common self-prescribed medicine in America today. It is used as an analgesic for almost all types of pain. Aspirin also has a specific anti-inflammatory effect, which makes it the drug of choice in treating certain kinds of arthritis, a very common problem among older people. Thus many older people are long-term users of aspirin in high doses (1-3 grams per day). Aspirin can cause microscopic bleeding of the gastrointestinal tract with a resulting loss of iron. Since iron needs are often increased in the elderly, the older person who is a regular aspirin user is in double jeopardy and must choose a diet that is high in iron.

There is also evidence that aspirin may compete with folic acid for a place on the protein molecule in blood which transports this vitamin to the tissues. Thus, less folic acid is able to reach the sites where it is active. In addition, some data suggest that aspirin may increase the rate of folic acid loss in the urine. For these reasons, a person who is taking large doses of aspirin over a long period of time should pay particular attention to consuming foods that are rich in folic acid. Finally, although the data are not conclusive, there are a number of studies which suggest that chronic use of aspirin will increase the need for vitamin C, thus requiring a higher intake of that vitamin.

Laxatives

Constipation is a very common problem in the elderly and while we feel that the best treatment for this disorder is to increase the amount of dietary fiber, many older people are, instead, chronic laxative users. Some laxatives may decrease vitamin D absorption and, if they contain mercury, may deplete phosphorus from bones. Both of these actions can aggravate the tendency towards osteoporosis. Mineral oil, a widely-used remedy for constipation, interferes with the absorption of fat-soluble vitamins, particularly vitamins A, D and K. Again, the resulting vitamin D deficiency may make an already poor calcium balance worse.

Antacids

While there is rarely a need for antacids, particularly in older people who generally have a decrease in stomach acidity, many elderly adults regularly use these preparations. If large amounts are used for long periods of time, and if aluminum hydroxide is one of the ingredients, phosphate deficiency can result. This is because dietary phosphate will react with the aluminum and form aluminum phosphate, which is passed in the stool. As a result, blood phosphate is kept at a normal level only by phosphorus released from bone. Again, the older person who is already suffering from bone demineralization is at particular risk.

Diuretics

In our society, where relatively large quantities of salt are consumed, the incidence

Food Sources of Nutrients Commonly Affected by Drugs

Nutrient	*Food Sources*
Vitamin A	*Liver, butter, cream, egg yolks, leafy green vegetables, deep yellow and orange fruits and vegetables*
B Vitamins Folic Acid	*Liver, yeast, leafy green vegetables, legumes, whole grains, fruits and other vegetables*
B_1	*Wheat germ, meat, liver, whole grains, peanuts, soybeans, corn*
B_2	*Liver, eggs, meat, milk, cheese*
Vitamin C	*Citrus fruits, strawberries, tomatoes, cantaloupes, broccoli, cabbage, green peppers, leafy greens, potatoes*
Vitamin D	*Fish liver oils, fortified milks, very small amounts in egg yolks, butter, liver, salmon, sardines*
Vitamin K	*Leafy green vegetables, liver*
Calcium	*Milk, cheese, leafy green vegetables, clams, oysters, almonds, legumes, water, tofu*
Iron	*Liver, meat, oysters, leafy green vegetables, dried apricots, prunes, peaches, raisins, legumes, nuts, whole grains*
Magnesium	*Whole grains, legumes, nuts, leafy green vegetables, water*
Phosphorus	*Liver, meat, eggs, milk, cheese, nuts, legumes, whole grains, refined cereals*
Potassium	*Meat, milk, leafy green vegetables, dates, bananas, cantaloupes, apricots, citrus fruits, bamboo shoots, prunes*
Zinc	*Oysters, liver, wheat germ, yeast, seafood*

Possible Causes and Solutions to Mild Gas Problems

Possible Cause	*Solution*
Carbonated beverages	Herb teas, fruit juices, water
Gulping or swallowing air	Relax, take small sips and bites
Beans and peas	Smaller portions; try different variety
Cabbage family (sulfur-containing vegetables	Cabbage, broccoli, brussel sprouts, cauliflower. Cook *without* placing a lid on the pot
Excess fiber	Reduce added bran (if used) or amounts of salad-type vegetables and/or fruits
Intolerance to milk sugar	Smaller portions of milk, yogurt, and cheese; omit when discomfort is persistent.
Specific sensitivity	Omit *on a trial basis* any one (at a time) of the following: carrots, raisins, bananas, apricots, prune juice, pretzels, bagels, wheat germ, pastries, potatoes, eggplant, apples, citrus fruits and bread.

Table IV. Commonly Used Drugs That Affect Nutrients

Drug	*Nutrient*	*Mechanism*
Cholestyramine (cholesterol-lowering agent)	Fats and fat-soluble vitamins	Inhibit absorption
Aspirin	Iron	Increasing bleeding
	Folic Acid	Compete for transport
Laxatives	Fat-soluble vitamins (A,D,K)	Inhibit absorption
	Phosphorus	Depletion from bones
Antacids	Phosphorus	Inhibit absorption
Diuretics	Potassium	Increase excretion
	Calcium	Increase excretion
Anticoagulants	Vitamin K	Inhibit utilization
Anticonvulsants	Vitamin D	Inhibit utilization
	Folic acid	
Corticosteroids	Vitamin D	Increase utilization
	Vitamin B	Increase requirements
	Zinc	Increase excretion
Alcohol	Folic acid	Decreased absorption
	Thiamine	Increased requirement & decreased absorption
	Vitamin B	Impaired conversion to active form
	Zinc & magnesium	Increased excretion
Nicotine (cigarettes)	Vitamin C	Uncertain
	Vitamin B	Uncertain
	Vitamin B	Uncertain

of high blood pressure increases with age. Therefore, many older people suffer from this ailment. One of the most common methods of treating high blood pressure is by using diuretics. These drugs induce sodium and water loss through the kidney. Diuretics are also used to treat people with chronic heart disease who may have a tendency to accumulate water in their tissues (edema). Along with the loss of sodium, which is a desirable effect, many diuretics will also promote the loss of potassium, an undesirable effect. The potassium must be replaced in order to avoid depletion of this essential mineral from the body. Therefore, foods rich in potassium should be consumed daily. If for some reason this cannot be done, a potassium supplement should be taken.

Some diuretics may also increase calcium excretion, a particularly unwanted side effect in older people, and a few can cause the depletion of other minerals. Anyone who uses diuretics on a regular basis should be under the care of a physician, who will recommend appropriate mineral supplementation when indicated.

Undoubtedly the use of drugs to alleviate many conditions is warranted. However, we must be aware of situations where drug abuse can cause a nutrient deficiency. The section on Dietary Guidelines indicates which foods are rich in nutrients that may be affected by drug use.

False Nutritional Claims

Older persons are a major target for opportunists who pander to people's needs to feel better, cure disease, look younger and lose weight rapidly. They also play on people's fears by trying to convince them that they are being poisoned by food additives and pollutants and by claiming that the whole food supply is being downgraded by processing. They thus pave the way to sell their "all natural" foods, which cost a great deal more and often have little overall effect on a person's health and longevity.

Listening to these claims can be quite dangerous. First, buying these supplements will undoubtedly decrease the amount of money available to buy goods from the standard four basic food groups. Second, excess intake of certain potentially toxic vitamins can cause serious health problems. Third, if these popular nutritional cures are used as a replacement for sound medical cures, especially in the case of serious illness, the ailment may get worse through lack of proper treatment.

One type of false nutritional claim that is found very often is that "health foods" are more nutritious and better than regular, store bought foods. The term "health foods" covers such items as 'natural foods' and 'organically grown foods'. Natural foods have minimal processing, additives or preservatives. Organic foods are those produced without the use of inorganic fertilizers and are processed without chemicals or additives. They include whole grain flour, molasses, honey, kelp, alfalfa, rose hips, and raw milk.

There is no evidence to support the claims that these foods are better than other foods. They still contain some pesticides and toxins like other foods at levels that are considered safe. Natural foods have no higher nutritional value than conventional foods; they just cost

"Non-Vitamins"
Which Are Not Essential to Health

Carnitine, or "Vitamin B"	*Used in fat metabolism, but made by the body from lysine*
Bioflavenoids, or "Vitamin P"	*Not useful in the treatment of any human condition*
Choline	*Found in all cell membranes, and does not combat arteriosclerosis*
Para-aminobenzoic Acid (PABA)	*Part of the folic acid molecule*
Inositol	*Made in the body when required*
"Vitamins" Q and U	*No function in humans*
Nucleic Acids (RNA and DNA)	*No evidence that they prevent aging*
Laetrile, or "Vitamin B"	*No function in humans, and does not combat cancer*
Pangamic Acid, or "Vitamin B"	*No evidence that it has any effect on any human disorder, including heart disease, aging, fatigue, diabetes, cancer, glaucoma, schizophrenia, allergies, breathing problems, or inflammation of the liver*

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more. Because people have to spend so much on these foods, they are forced to reduce the money spent on other foods that actually may be more nutritionally balanced.

Other common claims are that high doses of vitamins (megavitamin therapy) are beneficial. As mentioned before, this has not been proven and, in effect, can cause serious symptoms of toxicity. Unless there is a clear medical indication for the opposite, there is no reason to consume vitamins at levels higher than the Recommended Dietary Allowance.

A series of compounds have been claimed to be vitamins or to have special effects on the body. This is not true. Some of these "non-vitamins" are listed in the following table.

Links Between Diet and Disease

Osteoporosis and Periodontal Disease

There is general agreement that osteoporosis (brittle bones) results from a prolonged negative calcium balance due to a leaching of calcium from the bones. This process begins in the 30th year for women and the 40th year for men, with the disease being more common and more severe in women.

Some view this chronic demineralization as a part of physical aging and as primarily due to hormonal changes. Others feel that these changes in bone composition are at least accelerated by our low-calcium, high-phosphorus, high-protein diet. Regardless of who ultimately turns out to be right, there is no doubt that calcium supplementation, even when accompanied by a lowered phosphorus and protein intake, will not cure the disease once it has begun. The use of calcium supplements in the treatment of osteoporosis has not met with any significant success. However, we see little danger in calcium supplementation and reduced phosphorus intake and would recommend it for patients with osteoporosis as well as for older people in general, in the hope that calcium loss from bone composition can at least be partially curtailed.

The controversy over periodontal disease (loose teeth) is far more fundamental. The majority of investigators believe that the disease is primarily a chronic infection of the gums which leads to the erosion of underlying bone and subsequent loosening and loss of teeth. A small, but determined, minority believe that the disease is really osteoporosis of the jaw bone. They argue that the bone erosion leads to secondary gum infection resulting in the loosening and loss of teeth, and further, that calcium supplementation can reverse the

Table V. Calcium Sources

Food	*Weight*	*Serving*
Almonds, chopped	130 grams	1 cup
Buttermilk	245 grams	8 oz.
Cheddar cheese	42 grams	1½ oz.
Collard greens, chopped, cooked from frozen pkg.	170 grams	1 cup
Cottage cheese, creamed or uncreamed	340 grams	12 oz.
Evaporated milk, unsweetened	126 grams	4 oz.
Fluid milk, whole or skim low-fat milk,	245 grams	8 oz.
(with 2% milk solids added)	245 grams	7 oz.
Kale, cooked from frozen pkg.	260 grams	2 cups
Mackerel, pacific, canned	100 grams	3½ oz.
Tofu (soybean curd)	240 grams	2 pieces
Turnip greens, cooked from frozen pkg.	165 grams	1½ cups

process and actually cure the disease in many patients. What must be considered is the possibility that periodontal disease has more than one cause and that a few patients (probably the minority) develop loose teeth as a result of osteoporosis of the jaw bone. In these patients, calcium supplementation may be of some use. Again, the dangers of such treatment are nil, and even if the chances for success are somewhat questionable, we would recommend a trial of 1000 mg per day of calcium along with the dental therapy recommended for people with periodontal disease.

It is also recommended that the elderly reduce the intake of alcohol and smoking. Both of these are factors that increase the risk of osteoporosis which are controllable.

A list of good calcium sources is found in

Table VI. Typical Diet and Recommended Diabetic Diet

	Typical American Diet	*Recommended Diabetic Diet*
Carbohydrate	40% (high in simple sugars)	50%-60% (high in complex carbohydrates, e.g. starches and vegetables)
Fat	40% (high in saturated fat)	20%-30% (1:1:1 ratio of polyunsaturated to monounsaturated to saturated fat)
Protein	20%	20%
Fiber	low	high

Low Cost Sources of Certain Nutrients*

Nutrient	*Source*
Vitamin A	Liver, fresh carrots, sweet potatoes, margarine, powdered milk, eggs, frozen leafy vegetables
Thiamine *(vitamin B)*	Whole grain products, beans, liver, frozen leafy vegetables
Riboflavin *(vitamin B)*	Powdered milk, eggs, liver, whole grain products, frozen leafy green vegetables
Niacin and folic acid	Liver, whole grain products, beans
Vitamin C	Frozen concentrated orange or grapefruit juice
Vitamin D	Powdered milk
Vitamin E	Margarine, whole grain products
Calcium	Powdered milk, sardines (with bones), frozen leafy vegetables
Iron and zinc	Liver, whole grain products, red meat (lean)

**Because this table is based on the cost of the nutrient, more expensive sources are not included. Likewise, if a brand is specified (such as "powdered", "frozen" or "fresh") while there are other more expensive forms of the product, they are equally nutritious—just more expensive!*

table ". If a dairy product causes any gastrointestinal disturbance, we recommend reducing the amount consumed and trying it again after a few days.

Diabetes

Six million Americans suffer from diabetes, a disease in which there is not enough insulin made in the body to meet its needs. Insulin is produced in the pancreas and is needed for the tissues to take up glucose (blood sugar) from the blood for use as fuel. An insulin deficiency will result in high blood levels and low tissue levels of glucose. Theoretically, a person may be diabetic because the pancreas is unable to make insulin or because the tissues are not able to respond properly even though insulin is present. Both of these types of diabetes do occur. The type of diabetes which occurs in later life (usually in the 50's or 60's) is not associated with any abnormality in pancreatic beta cells. Insulin is produced in normal amounts (sometimes even in increased amounts) but the tissues of the body have somehow become resistant to the action of insulin. Again, the blood sugar will rise and the tissues will be starved for fuel. This type of diabetes also has a genetic basis. It is more common in certain families than in others. However, unlike the juvenile form, there is a nutritional component in the cause of maturity onset diabetes. It is much more common in obese people than in lean people. Thus, to the extent that diet is involved in obesity, consumption of too many calories is a contributing cause of diabetes. While the increased consumption of calories regardless of the source will increase a person's risk of contracting diabetes, ingestion of sugar, per se, will not. The increased amount of fat tissue increases the body's resistance to the action of insulin. For this reason, weight reduction alone may control this kind of diabetes.

Although nutrition plays only a limited role when it comes to the causes of diabetes, it plays a major role in the management of diabetes. Treatment of any patient with diabetes, regardless of the type, will have two major aims--to control the level of blood glucose and to prevent the serious complications of the disease. While insulin therapy may be of primary importance in treating people with

diabetes, proper nutrition will make it easier to achieve these aims.

Diabetes is often associated with high levels of lipids (fats) in the blood, which increases the risk of atherosclerosis. These high serum lipid levels can often be brought down by reducing the amount of total fat, saturated fat and cholesterol in the diet. Thus, the diabetic person should be on a diet which is lower in fat, saturated fat and cholesterol, and higher in polyunsaturated fats than the usual American diet. Lowering the percentage of total calories derived from fat will increase the percentage of calories derived from carbohydrates. Therefore, the best diet for an individual suffering from diabetes will be one that is relatively high in carbohydrates.

At the same time, we want to limit the amount of carbohydrates in the form of simple sugars. Simple sugar is absorbed very rapidly and will therefore raise blood sugar to very high levels before the insulin, which has been administered, can bring the levels back into the normal range. As a consequence, the preferred diet for a person with diabetes is a low-fat diet which has a normal protein content, a reduced content of simple sugars, and a very high content of complex carbohydrates (starches). In addition, there may be a benefit derived from consuming relatively large amounts of fiber. Table VI compares the typical American diet to a diet recommended for a person with diabetes.

A diabetic person should follow these guidelines:

- Fat should be limited to 25 to 30 percent of the total calories consumed.
- Saturated fat should supply 10-15 percent of the total calories, and vegetable fat (polyunsaturated and monounsaturated), the other 15 percent.
- Protein can range from 12-24 percent of all calories (not critical).
- Simple sugars should be kept to 10-15 percent of all calories consumed and only a small amount of this should come from refined sugars.
- The remainder of the calories (around 40 percent) should come from complex carbohydrates (usually starch).

Finding Sound Nutritional Information

One of the problems faced by many people is to find good sources of nutrition information. The following is a list of organizations which are valid sources of expert nutritional advice:

Accredited colleges and medical schools with nutrition departments.

The Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857.

The U.S. Department of Agriculture, Food and Nutrition Information Center, USDA National Agricultural Library, Room 304, 10301 Baltimore Blvd., Beltsville, MD 20705 (301-344-3719).

The USDA Extension Service at any land-grant university (see your local telephone directory).

The Department of Health and Human Services, Health Services Administration, U.S. Public Health Service, Washington, D.C. 20852, and the U.S. Government Printing Office, Pueblo, CO 81009.

The American Society for Clinical Nutrition, 9650 Rockville Pike, Bethesda, MD 20014.

The American Medical Association, Department of Foods and Nutrition, 535 N. Dearborn St., Chicago, IL 60610.

The American Dietetic Association, 430 N. Michigan Avenue, Chicago, IL 60611.

State and local dietetic associations.

The Nutrition Foundation, 888 17th St., N.W., Washington, D.C. 20006.

Common Herbs and Their Uses

Allspice	Lean ground meats, stews, tomatoes, peaches, applesauce, cranberry sauce, gravies, lean meat
Almond extract	Puddings, fruits, tea
Basil	Fish, lamb, lean ground meats, stews, salads, soups, sauces, fish cocktails
Bay leaves	Lean meats, stews, poultry, fish soups, tomatoes
Caraway seeds	Lean meats, stews, soups, salads, breads, cabbage, asparagus, noodles
Chives	Salads, sauces, soups, lean meat [illegible] vegetables
Celery seeds	[illegible]
Cinnamon	[illegible] breads, pastries
Curry powder	Lean meats (especially lamb), veal, chicken, fish, tomatoes, tomato soup, mayonnaise
Dill	Fish sauces, soups, tomatoes, cabbages, carrots, cauliflower, green beans, cucumber, potatoes, salads, macaroni, lean veal, lamb, chicken, fish
Garlic (not garlic salt)	Lean meats, fish, soups, salads, vegetables, tomatoes, potatoes
[illegible]	Lean meats, fish, poultry, salads, vegetables, fruits
Mace	Hot breads, apples, fruit salads, carrots, cauliflower, squash, potatoes, veal, lamb
Mustard (dry)	Lean ground meats, lean meats, chicken, fish, salads, asparagus, broccoli, brussel sprouts, cabbage, mayonnaise, sauces
Nutmeg	Fruits, pie crust, lemonade, potatoes, chicken, fish, lean meat loaf, toast, veal, pudding
Onion (not onion salt)	Lean meats, stews, vegetables, salads, soups
Paprika	Lean meats, fish, soups, salads, sauces, vegetables
Parsley	Lean meats, fish, soups, salads, vegetables
Peppermint extract	Puddings, fruits
Pimento	Salads, vegetables, casserole dishes
Rosemary	Chicken, veal, lean meat loaf, lean beef, lean pork, sauces, stuffings, potatoes, peas, lima beans
Sage	Lean meats, stews, biscuits, tomatoes, green beans, fish, lima beans, onions, lean pork
Savory	Salads, lean pork, lean ground meats, soups, green beans, squash, tomatoes, lima beans, peas
Thyme	Lean meats (especially veal and lean pork), sauces, soups, onions, peas, tomatoes, salads
Turmeric	Lean meats, fish, sauces, rice

Average Sodium Content of Basic Foods*

	Sodium (MG, Average Serving)
Fruits and juices	2
Fresh vegetables, beans and plain nuts	2-7
Grain products:	
Rye, oats, flour, pasta, farina, rolled wheat	5-7
Other leafy & root vegetables, and plain frozen vegetables	50-90
Meat, poultry, fish and eggs	75-80
Milk and yogurt	120-130
Organ meats and shellfish	200-300
Sandwich bread, rolls, and ready-to-eat cereals	120-300

**Prepared instant, canned and heavy-salted products have much higher values.*

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chapter 15

Some Psychosocial Influences on the Health Status of the Elderly: The Perspective of Social Epidemiology

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Even though the boundaries and orientation of social epidemiology are somewhat nebulous (Kasl 1977, Syme 1974), in general we may recognize within this segment of social science and medicine collaboration a primary concern with the psychosocial determinants of: illness or disease onset (incidence of new events), the course of illness or disease (exacerbations, repeat events), and the outcome of disease process and/or degree of recovery. There is also a concern with indirect psychosocial influences operating via medical care utilization and the whole gamut of contacts with health professionals and health services (health behavior, illness behavior, and the sick role behavior spectrum) and behaviors and practices with health implications (life-style, health habits).

Within an (idealized) infectious disease model, the role of psychosocial influences on health status can be schematically represented (Kasl *et al.* 1979) as those that affect: (*a*) initial immunity–susceptibility status, (*b*) exposure to infection among susceptibles, (*c*) development of inapparent versus clinical illness among the exposed, (*d*) medical care seeking among those with clinical illness, and (*e*) response to treatment and/or natural cause of illness.

Overall, then, psychosocial factors can influence human health in many different ways and through many different pathways—exposure

to risk factors, exposure to medical care system, differential susceptibility, social relationships, social change, habits and customs (Hinkle *et al.* 1976)—and none can be a priori rejected as irrelevant to social epidemiology.

This chapter deals specifically with the health of the elderly. It is a frequent and fully appropriate goal of descriptive epidemiology to zero in on one particular population subgroup and to describe its morbidity and mortality experience and its medical care needs. Many objectives and issues of public health planning and policy can make such a focused look at one subgroup intrinsically useful. However, if our orientation is *etiological*, and we are trying to understand the causal influences on variations in health status (analytical epidemiology), then the targeting of a particular population subgroup for scrutiny becomes a much more troublesome enterprise. The fundamental problem is that we create a presumption of uniqueness—that the processes under observation are special to the targeted population subgroup—and we collect evidence that grows and accumulates in splendid isolation from similar data on the rest of the population. Such intellectual and conceptual isolation at best leads to duplication of effort; at worst, it leads to misinterpretation of data and to adoption of distorted or misleading theoretical positions. It is our belief that such theoretical disasters as the disengagement hypothesis are due to intellectual straining after the uniqueness of the elderly, which would in turn justify why we study them separately.

The objective of this chapter is to sidestep the vast descriptive literature dealing with the association between age and the many indicators of health status and biological functioning, and to zero in on some of the psychosocial influences on the health status of the elderly. In view of the above comments, this task poses somewhat of a dilemma: to keep the elderly in focus without losing sight of the fact that the evidence and the etiological picture may or may not be unique to this population subgroup. One way out of this dilemma is to ignore it, as is done all too frequently in handbook chapters on the elderly; an author typically either reviews only the studies in which the elderly are the subjects and ignores the picture for the other population subgroups, or reviews the studies irrespective of the age range of the subjects (hence not dealing primarily with the elderly) and lets the reader assume that evidence relevant for the elderly is being examined. In this chapter we intend to put up more of a struggle with this dilemma. Essentially, we propose to concentrate on two types of evidence: First, studies that suggest that the association between a psychosocial risk factor and a health status indicator is notably altered or conditioned by age and second, studies that deal with psychosocial influences that are particularly relevant to the elderly, either

because they represent experiences found predominantly among the elderly (e.g., retirement, bereavement) or because such experiences have different social meaning for the elderly (e.g., residential moves). In addition, we will also briefly consider the issue of age in relation to health maintenance behavior and medical care seeking.

One of the most persistent and seductive notions in gerontology is the concept of biological aging as an intrinsic, *sui generis* process that can be separated from the accumulation of environmental influences and insults that the aging organism also experiences. For example, Busse (1969) distinguishes between "biological aging," those genetic processes that are time-related and independent of stress, trauma, or disease, and "secondary aging," which consists of disability resulting from trauma and chronic illness. If biological and secondary aging were cleanly separable conceptually and operationally, then it would be a primary task of social epidemiology of the elderly to study the interactions of social–environmental influences and the biological aging process as they affect health status. However, it seems to us that despite a great accumulation of normative data on age and biological functioning (e.g., Finch and Hayflick 1977), there is little evidence to support the notion that biological aging processes, independent of stress, trauma, and disease, exist and have been identified. We are not convinced that the numerous biological theories of aging (Shock 1977) can, at the moment, do much more than point us toward those age-dependent changes in biological functioning that are particularly uniform or particularly variable across diverse population groups.

CHOOSING INDICATORS OF HEALTH STATUS

It is useful to confront, however briefly, the issue of indicators of health status. This problem area has been examined many times (e.g., Balinsky and Berger 1975, Belloc *et al.* 1971, Berg 1973). The difficulty is not in the assessment of specific diseases; certainly, a large number of diagnostic criteria have been adequately operationalized. Rather, the problems arise when we aim for global or composite indices of health status; health-related social functioning and/or disability; subjective components of health status; or a clean separation of illness from illness behavior. It goes without saying that many additional problems arise when we are dependent exclusively on self-report interview methodology.

The range of typical health status indicators available to an epidemiologist include: general and specific mortality rates; expectations of

life at a specific age; rates of specific morbidity; levels of impairment (e.g., hearing, sight, paralysis of extremities); indices of disability (e.g., disability days, restricted activity days, bed days, hospital days, work loss days); contacts with the health care system (e.g., doctor visits, clinic visits). These indicators are obviously not interchangeable; moreover, they have unique problems: They never quite measure all of a phenomenon of interest, and they always measure, in addition, part of something that is not of interest.

Since the interests of social epidemiology and social gerontology are more etiological than descriptive, and since they concern more complex independent variables, the more common, straightforward indices of health status are generally found to be less useful and more opaque. For example, mortality data alone do not tell us which end of the disease spectrum is most influenced by the psychosocial variable in question: levels of risk factors, onset of clinical disease, gap between onset and diagnosis and/or treatment, case fatality, and so on. This is a serious limitation, since the mechanisms by which psychosocial variables influence health status are poorly understood; for example, the health consequences of some behaviors may become manifest 20 or 30 years after the individual engages in the behavior, whereas other behaviors appear to have much more immediate effects. Similarly, the cumulative effect of lifelong practices is rarely explored in most studies, and dose-response or length-of-exposure relationships have generally not been identified.

The self-evident "validity" of mortality as an end point makes this a seductive indicator. In contrast to prospective studies of new disease (morbidity), for which we need a cohort initially free of that disease, many psychosocial cohort studies of mortality establish at inception only that the subjects are alive. Since so many psychosocial variables are influenced by poor health status—which will obviously relate to subsequent mortality— we have a serious problem of confounding that we cannot directly assess.

Two examples illustrate this problem. The first concerns the often cited finding that work satisfaction can be a strong predictor of longevity, especially among men (Palmore 1971). Unfortunately, close inspection reveals that four of the six items reflect ability to carry out work rather than satisfaction. It is virtually certain that the index is sensitive to physical functioning and thus confounded with health status. The second example concerns the finding that aged individuals being institutionalized voluntarily had lower subsequent mortality rates than those who had no other alternative (Ferrari 1963). Since the concept of control (or internal–external orientation) is rapidly becoming a hot topic in health research (e.g., Krantz and Schulz in press, Strickland in press), we shall

keep hearing about this finding. Yet there is no question that seriously deteriorated health status is a major determinant of involuntary institutionalization among the elderly.

In an article provocatively entitled "The Failure of Success," Gruenberg (1977) reminds us that the life-saving technology of the past several decades has outstripped our health-preserving technology, with the net effect of worsening people's health, especially among the elderly survivors. The implication is that health status indicators such as mortality rates or life expectancy paint an incomplete or misleading picture, and that we need to be concerned also with indices that reflect disease, disability, social functioning, and "quality of life." One such useful index is presented by Sullivan (1971), who computed expectations for people 65 years old of years free of disability and free of bed disability, broken down by sex and race.

THE CHANGING RISK FACTOR PICTURE WITH AGE

Biological and psychosocial risk factors for a particular disease, or for adverse health status changes in general, may change in their potency as one goes from younger and middle-aged study samples to older subjects. The general issue here is the extent to which older age changes vulnerability to disease for a given level of risk factors.

The report of the Pooling Project Research Group (1978) on incidence of major coronary events in men reveals that the risk ratio goes up with age for blood pressure (and electrocardiogram abnormality), but goes down for serum cholesterol, cigarettes, and relative weight. Ostfeld *et al.* (1974) in their prospective study of stroke in an elderly population receiving welfare, found that, among those elderly free of preexisting cardiac and vascular disease, none of the following predicted stroke: blood pressure, ponderal index, cigarette smoking, serum cholesterol, and plasma glucose. Among those with preexisting disease, only blood pressure and ponderal index were significant risk factors for stroke.

Such findings as these suggest that, among the elderly, only high blood pressure remains as the risk factor of concern in the development of stroke and coronary heart disease. Conversely, the results indicate caution in initiating interventions regarding such life-style habits as smoking and diet in the elderly. Of course, no picture is as simple as this. For example, the data from Hagerstown (Abraham *et al.* 1971) revealed the highest prevalence of hypertensive vascular disease and cardiovascular renal disease among obese adults who were not obese as children; those

obese in both childhood and adulthood had lower rates. This might suggest that obesity among the elderly does continue as a risk factor for those diseases, but only among those who obesity is of more recent origin.

Broad sociodemographic factors may also change in risk factors with advancing age. Kitagawa and Hauser (1973) analyzed mortality data on United States' residents in relation to age and education. Among white men, standardized mortality ratios (SMR) for all causes revealed a negative gradient in relation to years of education only among those age 25 to 64; white men 65 and older showed no gradient whatever. Among white women, a somewhat stronger negative gradient was observed in the 25–64 age group than in the 65 and older group, but the latter still revealed a definite negative association between SMR and education. Analyses by cause revealed that the disappearance of the gradient among men 65 and older held for all major causes except two: For influenza and pneumonia and for accidents, the higher levels of education conferred an advantage even in those men older than 65. These data, overall, suggest a simple interaction between SMR, education level, and age, and a more complex interaction involving sex.

Analyses by socioeconomic level of city tracts and age (Antonovsky 1967) reveal the expected negative gradient in SMRs and its weakening in the older age groups. However, unlike the data on education, the gradient never quite disappears even in the oldest group (75 and older) and is about the same for both sexes. Computations of SMRs for men 20 to 64 by age and occupation (Antonovsky 1967, National Vital Statistics Division 1962) reveal that nonfarm laborers, the one group with a notable excess mortality, have an SMR of more than 170 in the 25–44 age group, but it drops to a little more than 120 in the 55–64 age group.

Race remains an ambiguous social indicator in health studies and presumably reflects many sociocultural variables in addition to average social class differences. Consequently, the race-dependent differences in various health status indicators that are also modified by age are difficult to interpret. For example, age-specific death rates are higher for nonwhites only until age 74; the situation then reverses (National Center for Health Statistics 1979). However, these do not appear to be additional years free of disability; days of restricted activity and days of bed disability continue to be higher among nonwhites even in the 75 and older age bracket (National Center for Health Statisitics 1972). Other studies also suggest changing race differentials for specific diseases with change in age. For example, the strong increase in rheumatoid arthritis with age holds only for whites; blacks have higher rates until age 64, while whites have higher rates in the 65 and older age group (Cobb 1971). Prevalence

rates of diabetes, determined in a mobile multiphasic screening program, are much higher among blacks than whites, but over age 65, the rates are virtually identical (Adler *et al.* 1966).

Analyses of 1959–1961 mortality by marital status (National Center for Health Statistics 1972) clearly document the well-known excess mortality associated with the three marital status categories of single, widowed, and divorced (compared with married). Moreover, in 11 of the 12 sex-by-race by status groups, the elevated SMR goes down in the older age groups: Only among divorced nonwhite women does the SMR show no change with age, remaining in the vicinity of 135. Additional analyses of similar mortality data from 1940 and 1949–1951 reveal one interesting secular trend: Among divorced women of both races the SMRs went up with older age groups for the 1940 and the 1949–1951 years. In other words, in 1940 divorced older women had much higher SMR than divorced younger women; by 1959–1961, this trend was reversed for white women and wiped out for black women. Additional analyses of the 1959–1961 mortality data by cause (e.g., arteriosclerotic heart disease, ICD [International Classification of Diseases] 420; vascular lesions affecting the central nervous system, ICD 330–334; malignant neoplasm of digestive organs and peritoneum, ICD 150–159) repeatedly confirm the decline in SMR for single, widowed, and divorced people in older age groups.

Data from the Human Population Laboratory (HPL) survey of almost 7000 adults in Alameda County have been examined for the relationship between health habits and mortality. Preliminary analyses (Belloc 1973) suggested that only the benefits of physical activity persist into old age. More recent analyses with a refined health practices index (smoking, alcohol consumption, physical activity, sleep, and relative weight), however, reveal that even among subjects 70 and older, a low score on positive health practices is associated with significantly greater mortality. These data are summarized in Table 15.1. It is also worth noting that there is not much of an association between age and health practices for either men or women.

The changing risk factor picture with advancing age becomes most complex—and most fascinating—when some factors become less potent while others emerge as more potent. Haynes *et al.* (1978), in their report on the relationship of selected psychosocial factors to coronary heart disease (CHD) in the Framingham study, showed that the Type A personality dimension was significantly associated with CHD among both men and women, but only in the younger age group (45–64); among older (65 and older) men and women, this association did not hold. On the other hand, marital dissatisfaction and/or marital disagreement were

TABLE 15.1
Mortality Rates from All Causes (per 100) by Health Practices Index, Age, and Sex, Alameda County, California 1965–1974

Health Practices Index (number of positive practices)	30–49		50–59		60–69		70+	
	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number
			Men					
0,1,2 positive health practices	9.3	(323)	19.7	(122)	30.9	(81)	77.6	(58)
3 positive health practices	3.1	(485)	16.3	(190)	34.8	(132)	66.3	(86)
4,5 positive health practices	1.2	(594)	6.9	(189)	17.7	(113)	50.7	(75)
			Women					
0,1,2 positive health practices	5.7	(318)	10.3	(136)	30.4	(92)	55.1	(69)
3 positive health practices	3.4	(555)	8.8	(205)	16.6	(157)	42.2	(147)
4,5 positive health practices	1.7	(662)	5.6	(233)	9.4	(138)	43.4	(129)

associated with CHD among men and women, but only in the older age group. Interestingly, an index called "aging worries" showed an association with CHD among younger men and women only. Equally fascinating results are to be found in the study of acculturation and CHD among Japanese men living in California (Marmot and Syme 1976). The basic finding was one of low CHD prevalence among the more traditional Japanese–Americans, a result that could not be accounted for by differences in the major coronary risk factors. How did this picture change for different age groups? On one index, "culture of upbringing," the benefits of being traditional weakened considerably in the oldest of three age groups (55 and older). On another index, "cultural assimilation" (degree of retention of Japanese cultural forms), it was the oldest group that showed the biggest differences in CHD prevalence due to degree of assimilation.

In summary, then, the selected findings discussed in this section were primarily intended to alert the readers to a particularly interesting issue: the changing risk factor picture with age, and what that may say about the vulnerability of older people. We cannot make any claims that these findings are easy to interpret or that they form a coherent whole. Certainly it is possible that, in part, we are simply observing the selective survival of the fittest. Similarly, calculations intended to reveal the strength of the impact of a particular variable on health status, such as standardized morality ratio or relative risk, are ratio calculations that encounter a ceiling effect when the outcome variable is quite common in the total group under observation (e.g., morality among the very old). Calculations based on linear differences (e.g., difference in percentage between two groups) might lead to somewhat different statements regarding the changing risk factor picture. However, neither of these explanations is particularly compelling when one finds subgroup differences, such as the difference between men and women in the impact of education on mortality among younger and older persons, or when new risk factors emerge as others weaken among the progressively older age groups in the study sample.

The results from the Pooling Project Research Group (1978) and the stroke study (Ostfeld *et al.* 1974), on one hand, and from the analysis of the health habits among older Alameda County residents (Berkman 1977), on the other, reveal some troubling differences in the significance of smoking, obesity, and excercise among the elderly. It is not yet clear, for example, to what extent exercising among the elderly may be a more sensitive index of health status than self-reports of disability, chronic conditions, and symptoms. Thus, adjusting for level of health, based on the later indicators, may not remove all of the variation in prior health

status, and amount of exercise among elderly would remain somewhat contaminated as a predictor of mortality.

In the long run, however, we need a substantive rather than methodological interpretation of the findings on the changing risk factor picture. This will call for a broad life-cycle perspective and for an understanding of the adaptation processes of different age groups. For example, the impact of social status variables may differ because life-style adaptations and aspirations change with age and because, in retirement, the effects of some components of social status may be considerably blunted. Ultimately, in order to understand the changes in biosocial vulnerability of people as they age, we will need to know more about the intrinsic, *sui generis* process of biological aging (if it exists), the cumulative impact of environmental conditions and experiences, and the changes in the meaning and dynamics of the psychosocial risk factors under scrutiny.

THE IMPACT OF SELECTED SOCIAL EXPERIENCES ON THE HEALTH OF THE ELDERLY

In this section, we propose to look at the impact of three types of psychosocial experiences or changing conditions: social networks and relationships, residential environments, and retirement. While these three topics represent an illustrative rather than a comprehensive coverage of the stress and disease literature (e.g., Dohrenwend and Dohrenwend 1974, Eisdorfer and Wilkie 1977, Henry and Stephens 1977, Hill 1976, Kasl and Reichsman 1977, Lazarus and Cohen 1976, Levi 1971, Lipowski *et al.* 1977), it is also true that they are three types of situations that are highly salient to the elderly and for which the accumulated research literature is quite plentiful. In contrast, the general literature on stressful life events, in which the combined impact of many possible events is studied, seldom deals specifically with elderly subjects and includes many events of limited relevance or applicability for the elderly. Nevertheless, it is interesting to note that the elderly tend to report fewer events and score the list of events lower on severity or seriousness (Masuda and Holmes 1978).

Social Networks

The importance of maintaining social connections for the physical and mental well-being of an individual has been recognized for some time

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(Durkheim 1951, Freud 1926, Bowlby 1958). Recently, investigators have hypothesized that social and community ties may alter host resistance and consequently play a role in the etiology of a wide range of diseases (Cassel 1976, Kaplan *et al.* 1977, Cobb 1976, Antonovsky 1972). Social isolation has also been proposed as a critical aspect of the aging process itself (Lowenthal 1964, Cumming and Henry 1961). It is commonly expressed that the elderly are an isolated group with widowhood, retirement, and grown children leaving home bringing about an irreversible loss of social attachments and community ties. Thus, if the relationship between social isolation and poor health is a causally strong one, we would expect this to have profound effects among the elderly for whom such losses are common. In fact, while there is some evidence to suggest that social networks play a role in disease etiology, there is less convincing evidence regarding increasing social isolation as an age-linked phenomenon, and even less evidence supporting the notion that the relationship between social networks and health status may be unique to, or different for, the elderly.

In the following pages, we will briefly review the research relating social and community ties to health status among people of all ages. We will then discuss the prevalence of such ties among the elderly and review some evidence indicating the potential of some factors to modify the impact of social losses and isolation on health status in this group. Finally, investigations will be presented in which the relationships between social networks and health among the elderly are explored.

MARITAL STATUS

It has been repeatedly observed that those who are married have lower mortality rates than those who are single, widowed, or divorced (Ortmeyer 1974, Durkheim 1951, Price *et al.* 1971). This mortality risk does not appear to be as great for women as for men and seems to decline with age. Some evidence also suggests that the relationship between marital status and health is independent of many "traditional" physiological risk factors. In a random sample of 6672 men and women between the ages of 18 and 79, Weiss (1973) examined the relationship between marital status, coronary heart disease (CHD) and serum cholesterol, systolic and diastolic blood pressure, and a ponderal index. Although Weiss found increased CHD mortality rates present among the nonmarried to some extent at all ages above 25, his results revealed that no differences in any risk factor explained the married/nonmarried CHD mortality differential. In fact, there were no consistent differences in any of the risk factor levels between married and nonmarried men and women at any age levels. The excess risk in CHD found among the nonmarried

is, thus, not due to any increases in any of the more obvious CHD physiological risk factors.

The association between widowhood and increased morbidity and mortality is particularly striking. Maddison and Viola (1968), Marris (1958), and early studies by Parkes (1964) indicate that widows, especially in the first year following bereavement, report many more complaints about their health, both mental and physical, and believe they have sustained a lasting deterioration to their health. The relationship between widowhood and increased mortality risk from a wide variety of diseases has been reported both in studies using vital statistics (Kraus and Lillienfeld 1959; Young *et al* 1963, Cox and Ford 1964, McNeil 1973) and in cohort studies (Rees and Lutkins 1967, Clayton 1974, Gerber *et al.* 1975, Ward 1976).

In one of the more conclusive studies, Parkes, Benjamin, and Fitzgerald (1969) report that of 4486 widowers 55 and older, 213 died during the first 6 months following bereavement. This is 40% above the expected rate for married men the same age. After 6 months, the rates gradually fell back to those of married men and remained at that level. Through an analysis of husbands' and wives' concordance rates for cause of death, the authors concluded that neither the sharing of similar pathogenic environment nor the tendency toward the selection of the unfit to marry the unfit (homogamy) was likely to explain more than a part of the increased 6-month mortality rate.

The existence of a supportive marriage has been shown to mediate between stressful life events and poor health outcomes. In one study of the mental and physical health consequences of job loss due to a factory shutdown, Gore (1978) reports that those men who had "the emotional support of their wives while unemployed for several weeks had few illness symptoms, low cholesterol levels, and did not blame themselves for loss of job." In general, men who were both unemployed for a longer time and unsupported tended to have the worse health outcomes (Cobb and Kasl 1977). In another study of psychiatric disturbance among women, Brown *et al.* (1975) found that having a husband or boyfriend who was a confidant served as a powerful mediator between a severe event or major difficulty and onset of psychiatric disorder. In this sample of women aged 18 to 65, 38% of those who had a stressful event and no husband or boy friend as confidant had onset of disturbance. (For those without such a confidant or without severe event, the percentage of psychiatric disturbance was under 4%.) When the confidant named was a sister, mother, or friend seen weekly, the relationship was not observed to mediate between life events and psychiatric disturbance.

These data suggest that there is something protective about a supportive spouse or partner that is capable of shielding an individual against

the otherwise deleterious effects of some objective life circumstances. The morbidity and mortality findings also indicate that the loss of a spouse, a major enduring tie to another person, may be at least a precipitating factor in the increased death rates found among widowers. The relationship appears to be at least to some extent independent of the traditional CHD physiological risk factors, homogamy, and equal exposure to pathogenic environments.

The elderly, particularly elderly women, are increasingly likely to lose a spouse with advancing years. Jacobs and Ostfeld (1977), in a comprehensive review on the mortality of bereavement, estimate that 2–3% of married Americans over the age of 50 will become widowed each year. Between the ages of 65 and 74, 10% of men and 43% of women are widowed. For those 75 years and older the respective percentages are 29.5 and 70.2 (Siegal 1975). Clearly, this is an extremely frequent event among the elderly. However, there is also some evidence to suggest that the nature of bereavement is in some ways modified for the elderly. Several investigators (Stern and Williams 1971, Gramlich 1968, Gerber *et al.* 1975, and Heyman and Gianturco 1973) indicate that grief among the elderly is not the same as grief at younger ages. Jacobs and Douglas (1979) have summarized this work, reporting that among the elderly a loss is faced with more cognitive acceptance and is associated with less numbness, denial, and guilt. However, hallucinations and illusions and psychosomatic symptoms may occur with greater frequency. Jacobs and Douglas (1979) suggest that these differential characteristics of grief among the elderly may be the result of the process of anticipation of death, which is probably associated with older age. This ability to anticipate and accept widowhood may also play some role in the decreased relative risks associated with bereavement at older ages reported by researchers (Kraus and Lilienfeld 1959, McNeil 1973). This finding also supports Neugarten's (1970) viewpoint that what makes events traumatic is their being "off time" and unanticipated. "Major stresses," she emphasizes, "are caused by events that upset the sequence and rhythm of the life cycle . . . when the empty nest, grandparenthood, widowhood, or retirement occur *off time* [pp. 86–87]." It may also be that the experience of becoming a widow or widower at a time when one's peers are also becoming single provides a structural support that buffers against some of the stressful circumstances encountered by younger widows and widowers. We discuss this topic in greater detail in the next section.

OTHER SOCIAL TIES

Apart from spouses, other social ties are relied on by most people to fulfill a variety of emotional and pragmatic needs. Some of these ties are

characterized by enduring and emotionally important relationships, while other contacts are characterized primarily by their task orientation. Some people in these links may fulfill a variety of needs; others may have one specific need for which they are relied on. Taken as a whole, these relationships and informal associations form a web or a social network in which most people spend a significant part of their lives. Although network configurations have been described in detail by many social scientists, relatively little is known about the impact that various network configurations have on health status. We will briefly review some of the evidence relating social networks to health status and then focus on situations of special interest to the elderly. For more extensive reviews on the topic of health and social networks the reader is referred to two recent papers (Kaplan *et al.* 1977, Cobb 1976).

Most health and network investigations have focused on mental health, in terms of either psychiatric disturbance, morale, or symptomatology. Phillips (1967), in a study of 600 adults, finds that people who have frequent contacts with friends, neighbors, and organizational associates (taken together or separately) report higher rates of "being happy" and are less likely to score in the "impaired" category on Langner's 22-item scale. Henderson *et al.* (1978a), in a study of a random sample of 142 adults in Canberra, have also reported a strong inverse relationship between social bonds and the presence of neurotic symptoms. In a larger sample, Henderson (1978b) confirmed these findings and found that when controlling for level of adversity, as measured by life events, there was a statistically significant decline in symptoms with increasing level of social bonds. An indirect test of the importance of extended ties is provided by a study by Wechsler and Pugh (1967) of approximately 25,000 first admissions to Massachusetts mental hospitals. The investigators hypothesized that the difference between an individual's characteristics and those of others in his community would represent the degree to which there was an easily available peer group to promote the formation of interpersonal relationships. In the study, people who did not "fit" in terms of age, marital status, occupation, or place of birth were found to have higher than expected rates of hospital admissions.

Social support systems have also been presumed to play a crucial role in problems with pregnancy, differential efficacy of treatment, and the process of recovery and survival. For example, in a study of primiparae army wives, women with many life changes and many psychosocial resources had one-third the pregnancy complication rate of women who also had many life changes but few psychosocial resources (Nuckolls *et al.* 1972). In another study of social factors and postpartum emotional problems (Gordon and Gordon 1967) the absence of supportive family

and friends was an important predictor of postpartum depression. An example of social support influencing treatment effects is the study of steroid requirements for chronic asthma patients (DeAraujo *et al.* 1973): the Berle Index, a composite measure of psychosocial resources including family and interpersonal relationships, was found to be negatively associated with steroid requirements. Greater use of health services in general appears to be associated with the feeling of not having enough friends (Segal *et al.* 1967) and with poorer integration into a new society (Shuval *et al.* 1970). Cobb (1976) in his review suggests that withdrawal from alcohol and compliance with medical regimes are all tied to social support and affiliation. Haynes and Sackett (1974), in a review of 22 articles concerning compliance and social support, report that for 15 of the studies, evidence shows that variables relevant to social support are associated with compliance to therapeutic regimes. One article reported negative evidence, and six showed no difference. And there are many studies that have examined the positive role of social support in such crises as bereavement and severe illness, and in the process of recovery and rehabilitation (e.g., Croog *et al.* 1972, Doehrman 1977, Hyman 1972, Litman 1966, Walker *et al.* 1977).

The research results discussed so far tend to focus on the importance of what we naturally think of as strong ties (e.g., ties with friends and family, characterized generally by emotional intensity, intimacy, and reciprocity). However, another aspect of network analysis stresses the importance and cohesive power of what are usually defined as "weak ties" (Granovetter 1973). Such ties are characterized by lack of intimacy and by the limited time spent in the relationship. Granovetter argues that these ties may be of critical importance in the diffusion of influence and information, mobility opportunity, and political and community organization. Walker *et al.* (1977)suggest that such weak ties aid the adjustment of the bereaved at a time when they need new information and new contacts. Other studies also indicate that people who have more differentiated networks or more varied types of sources of contact may have better access to medical care resources (e.g., Lee 1969, McKinlay 1973) and to have spouses with more successful recoveries from heart attacks (Finlayson 1976). It would appear that closed networks, although closely knit and capable of providing strong social support, may also exert a limiting influence by reducing access to information and resources; when the dominant in-group values and beliefs are incompatible with appropriate preventive behavior or medical care seeking, the social support from closed networks may be associated with poorer health status (e.g., Suchman's [1966] analysis of this issue).

The relationship between nonintimate "weak" ties and health status

has not been well investigated. Most research in this area has been limited to the study of group affiliations, organizational membership, and social participation instead of more direct measures of extended ties. Palmore and Luikart (1972), in an analysis from the Duke adaptation study of 502 people aged 45 to 69, report that while self-rated health was the strongest variable associated with life satisfaction, organizational activity was found to be second. Similarly, in a study of alienation and social structure in a small city (Mizruchi 1960), formal social participation was found to be negatively associated with alienation, even when controlling for social class position. These results agree with Srole's (1956) original findings.

Church attendance has long been thought to be positively associated with mental and physical health. It is unclear whether this is the result of religious belief, associated favorable health behaviors, associated sociodemographic factors, or support provided by a group of people. Compared with people who attend church infrequently, churchgoers have been found to respond more favorably to cervical cancer screening programs (Naguib *et al.* 1968), have a lower incidence of tuberculosis (Comstock *et al.* 1970), and have decreased risk of arteriosclerotic heart disease, pulmonary emphysema, suicide, cirrhosis of the liver (Comstock and Partridge 1972), and high blood pressure (Graham *et al.* 1978). The comparatively good health status of certain religious groups, for example, Seventh Day Adventists and Mormons, has also been noted; the most plausible explanation of this difference is presumably in terms of their favorable health behaviors. An Israeli study (Medalie *et al.* 1973) has reported a lower incidence of myocardial infarction among the more religious subjects. However, in contrast to the above evidence that religion may play a role in mortality and new morbidity, response to serious illness seems to be little influenced by different dimensions of religious identity (Croog and Levine 1972).

A more precise understanding of the above data on religion and health status is of more than academic interest. Since frequency of church attendance appears to decline with age among the elderly, even as their religious feelings and attitudes grow stronger (e.g., Moberg 1968), it is important to know whether the influence on health status involves the social interaction associated with attendance or certain feelings and beliefs that require no particular social setting to be effective.

Studies dealing with the association between social isolation and health are a natural extension of our concern with strong and weak social ties. However, there is a cause and effect issue concerning these data that is even more difficult to disentangle than for the studies already discussed. Since few of the isolation studies are prospective or longitudinal,

it is impossible to know whether social isolation predisposes people to low morale, depression, or other health consequences or whether it is the result of such conditions. Furthermore, it is likely that some of the observed relationships are confounded by the presence of other variables, such as marital status and socioeconomic status, which are themselves predictors of many of the outcomes measured in these studies.

In what ways does this evidence have any bearing on our understanding of health problems of the elderly? First, it is frequently assumed that with increasing age comes increasing social isolation. The increasing disabilities and functional limitations that come with age make it more important to have social relationships and environments that will help the elderly maintain themselves. In terms of the most obvious of social contacts—those which result from living arrangements—it is interesting to note that the majority of men and women older than 65 (79% of men and 59% of women) live with other family members, including spouses (Sussman 1976). Among the widowed this situation is different and appears to have changed substantially over the last 30 years. Chevan and Korson (1972), in an analysis of United States census data, report that 50.4% of widows and 47.0% of widowers in 1970 reported living alone. These percentages are double what they were in 1940. In this analysis, black widows and widowers were less likely to live alone than white widows and widowers; and those with more children and less income and education lived alone more than people with fewer children and in higher status groups. Among blacks but not whites, women were less likely to live alone than men.

While living with others protects one from the most severe forms of social isolation, living alone should not be automatically equated with social isolation. Much research indicates that older single people prefer to live alone but close to their children (Troll 1971, Rosenmayr and Köckers 1966). Shanas (1967) has presented international data suggesting that among older people with living children, for more than three-fourths the nearest child was either in the household or within an hour or less distance from him or her. The growing literature on parents and grown children (Adams 1968, Sussman 1953, Townsend 1957, Marris 1958) also indicates an effective, modified extended family structure in the United States and other modern European countries.

Data from the Human Population Laboratory (HPL) Survey of almost 7000 adults in Alameda County, California, in 1965 reveal few decreases in social contacts with age, with a few important exceptions. Table 15.2 reveals that only group membership shows a consistent inverse relationship with age. Other investigators have reported somewhat weaker inverse relationships for men but no association with age for women

TABLE 15.2
Percentage of Men and Women without Social Contact by Marital Status and Age and Source of Contact, Alameda County, California, 1965[a,b]

	30–49		50–59		60–69		70+	
	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number
Men								
None or few contacts with friends and relatives								
Married	16.4	(1209)	12.0	(446)	15.3	(268)	18.2	(143)
Nonmarried	21.8	(175)	16.4	(55)	34.5	(58)	23.9	(71)
No group membership								
Married	22.4	(1227)	19.7	(446)	28.7	(268)	42.7	(143)
Nonmarried	34.9	(175)	34.5	(55)	44.8	(58)	52.3	(76)
No church membership								
Married	71.1	(1227)	65.9	(446)	70.5	(268)	68.5	(143)
Nonmarried	76.9	(175)	70.9	(55)	80.7	(58)	75.0	(76)
Women								
None or few contacts with friends and relatives								
Married	15.4	(1249)	10.0	(401)	9.4	(202)	12.8	(86)
Nonmarried	16.1	(286)	10.2	(167)	12.9	(179)	13.3	(241)
No group membership								
Married	32.7	(1249)	37.3	(407)	55.8	(208)	56.2	(89)
Nonmarried	42.3	(286)	44.9	(167)	54.7	(179)	62.1	(256)
No church membership								
Married	66.7	(1249)	60.9	(407)	58.7	(208)	57.3	(89)
Nonmarried	76.9	(286)	65.2	(167)	63.1	(179)	54.3	(256)

[a] From Human Population Laboratory.
[b] Lower totals in age cells are due to missing data.

(Booth 1972) or a weak relationship without controlling for sex (Harvey and Bahr 1974). Among women, church membership increases with age. Contacts with friends and relatives do not vary greatly by age except among nonmarried men aged 60 to 69 who show a sharp decrease in contacts. The finding that single men in this age group are more than twice as likely as their married counterparts to report few contacts agrees with earlier findings (e.g., Blau 1973). The older single man is likely to be in a particularly deviant position since few men aged 60 to 69 are single. Having possibly lost old sources of friendship, originally established through work contacts, marriage, and other social affairs, he is now likely to be an odd person at social gatherings with friends and family. The older woman, in contrast, is likely to know more people in her similar situation (since there are more) and is likely to have an easier time making social contacts. Blau (1973) also notes that, incidentally, this situation disappears for people over 70 when the incidence of widowhood increases dramatically. This diminished difference is also evident in the HPL data. The greater ability of women, compared with men, to maintain intimate friendships with both family and friends has been reported at several other life stages besides the elderly (Arth 1962, Lowenthal *et al.* 1975, Booth 1972, Powers and Bultena 1976).

To summarize the association of social and community ties with age, we might say that the elderly are less likely than younger men and women to maintain extensive contacts from many sources; however, in most cases these differences are not large. There are important exceptions to this pattern. People who are in structurally deviant positions appear to have a more difficult time maintaining contacts, that is, widowers aged 60 to 69. Furthermore, although space does not permit us to review this evidence, both socioeconomic status and health status exert a powerful influence on the elderly person's abilities to see other people.

The health consequences, both mental and physical, of social isolation do not appear to be very different for elderly people than for people at other ages, but the data are very limited and fragmentary in this area. Studies of people 60 and older in San Francisco suggest that neither lifelong isolates, those who have a voluntary reduction in social activity, nor elderly people who face age-linked trauma such as widowhood or retirement appear to be more prone to hospitalization for mental disorder than others; however, those who have tried and failed to establish relationships may be more vulnerable to mental disorders (Lowenthal 1964, 1965, and Lowenthal and Boler 1965). These data are cross-sectional and the results must be interpreted with great caution since the direction of causation is unknown.

Analysis of mortality data from the Human Population Laboratory suggests that older people who lack social connections are at increased

risk of dying in a 9-year follow-up period (Berkman and Syme 1979). Table 15.3 shows age and sex-specific mortality rates by levels of a social network index. The index contains, in addition to marital status, information on contacts with friends and relatives, church membership, and formal and informal group associations. The general finding is one of increased mortality among those with fewer social ties; this holds for both men and women and persists when one adjusts for social class, initial health status, and health practices. Calculations of relative risk for different age and sex groups reveal only a slightly lower relative risk in older age groups and the diminution in relative risk by age not very regular. Calculations done on the 70 and older group, in which a little more than 50% died during the follow-up period, still reveal the predictive power of the social network index. It thus appears that social isolation does not particularly diminish in its potency as a risk factor for mortality in higher age groups. Since the national mortality data by marital status, discussed earlier, revealed a reliable diminution of standardized mortality ratios by age, this difference in results may suggest that the other items in the social network index are particularly notable predictors of mortality in the older population.

Residential Environments and Residential Moves

In this section, we wish to consider briefly selected aspects of the large literature on residential environments of the elderly. Because of limitations of space, we will provide only highlights of this literature, rather than a fully referenced and detailed review; the reader is referred to several recent comprehensive reviews (Carp 1976, Kasl and Rosenfield 1980, Lawton 1977, Lawton and Nahemow 1973) for a more detailed overview.

The great majority of studies deal with one of four topics: (1) the impact of new housing environments, such as planned housing for the elderly; (2) the impact of institutionalization and of institutional environments, (3) the impact of residential moves or relocation as stressful experiences, and (4) the impact of special residential settings, particularly retirement communities. There is wide consensus that the effects of the residential environment (that is, defined in physical terms and encompassing housing and neighborhood conditions, including services and facilities) cannot be understood in isolation, but must be seen in complex interaction with the characteristics of the individual and the nature of his or her social environment. Such a viewpoint leads to the suggestion that this section be best viewed as an elaboration and extension of the previous one on social networks, except that now the interactive effects

TABLE 15.3
Mortality Rates from All Causes (per 100) by Social Network Index Age, Sex-Specific Rates, Alameda County, California, 1966–1974

Social Network Index	30–49		50–59		60–69		70+	
	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number
Men								
I (Most connections)	2.4	(457)	9.6	(197)	21.8	(110)	20.0	(54)
II	3.1	(450)	12.1	(157)	26.3	(95)	59.5	(42)
III	5.3	(396)	18.2	(121)	33.0	(88)	65.2	(89)
IV (Least connections)	6.1	(99)	30.8	(26)	39.4	(33)	88.2	(34)
Women								
I (Most connections)	1.5	(460)	7.3	(205)	9.7	(93)	30.4	(56)
II	2.0	(402)	4.9	(122)	16.7	(78)	46.3	(41)
III	4.3	(514)	8.0	(188)	17.7	(158)	44.2	(156)
IV (Least connections)	6.9	(159)	15.3	(59)	29.4	(58)	55.4	(92)

of social and residential environments are being discussed. Thus, for example, rehousing studies reflect both the impact of improved physical conditions of the dwelling unit as well as the effects of the disruption of social networks that frequently accompanies rehousing. Similarly, dimensions of residential distance and crowding exert variable effects, depending on various social characteristics of the residents and the degree of social homogeneity of the neighborhood.

Studies of voluntary residential moves to better housing point to relatively modest benefits (e.g., Lawton and Cohen 1974, Lawton *et al.* 1978): These are strongest on indices of well-being that deal specifically with residential conditions, intermediate on indices of social activity and general evaluations of one's current life circumstances, and weakest on the more traditional indicators of mental health and physical health status. Possibly, elderly movers will experience more changes in health status (for better and for worse) than nonmovers, but no average benefit (Lawton and Yaffe 1970). In these and similar studies, it is unlikely that the modest results can be fully accounted for by the interpretation that the adverse effects of the social uprooting wipe out the benefits of the better housing. Only the Victoria Plaza study (Carp 1966) found impressive benefits due to rehousing; moreover, these benefits appear to persist through 8 years of follow-up (e.g., Carp 1977a). Unfortunately, the results of this study are atypical and the reasons for this a matter of some controversy (Kasl and Rosenfield 1980).

Cross-sectional studies of housing environments and health of the elderly do not contradict the conclusion of—at best—a weak impact on health. Many of the studies are actually more concerned with social dimensions of the residential environments (particularly age composition) and tend to focus on social activities and social interaction (e.g., Rosow 1967). These studies are in reasonable agreement about the results that link amount of social interaction to physical proximity and sociodemographic homogeneity. However, in spite of numerous other studies that have demonstrated an association between social interaction and some indicator of physical or mental health status (most frequently life satisfaction), it has been exceedingly difficult to make the full linkage from residential environment to social interaction to health status and then attach a large undirection causal arrow next to it.

The factors of interest to studies of the housing of elderly have traditionally centered on neighborhood facilities and services. More recently, however, a good deal of interest has switched to issues of transportation and crime (e.g., Cantilli and Shmelzer 1971, Goldsmith and Goldsmith 1976). The latter topic is a good illustration of the complexity of the issues involved: Simple cross-sectional surveys have not yet pin-

pointed the health costs of crime for the elderly, but any talk that such costs have been exaggerated would be premature, since such study designs are inadequately probing. For example, while the elderly are less likely to be victims of crime, certain types of crimes (e.g., larceny with personal contact) and certain locations (e.g., inside the dwelling, especially involving age-integrated housing) are relatively overrepresented among the elderly. Moreover, older people are more vulnerable to the impact of crime and their fear of crime can be at the same time greater and less closely tied to the actual "objective" crime rates in their neighborhood. Thus actual and potential (subjectively appraised) exposure to crime must be considered, especially since the latter is, in part, influenced by a sense of integration into informal helping networks. Defensive maneuvers that lower victimization rates but severely restrict the mobility and life space of the elderly, thus affecting their quality of life, have yet to be assessed for their impact on mental health. Specific targeted longitudinal studies of elderly crime victims also are still to be undertaken.

Involuntary residential changes of the elderly include relocation within the community, institutionalizations, and institutional transfer. It is generally agreed (e.g., Carp 1976, Lawton 1977) that elderly people as a group are less likely to make residential moves, less likely to desire such moves, and are less successful in anticipating their mobility behavior. Attachment to people in the community and to a place is the primary reason for the older person's unwillingness to make a residential move. Thus, there is every indication that such unplanned or unintended moves should have adverse health impact on the elderly.

Unfortunately, there is a dearth of longitudinal and fully prospective studies that could most securely assess the health impact. This is particularly disturbing in the case of the institutionalization literature, in which the phenomenon is so complex and the potential for confounding influences quite great (Kasl and Rosenfield 1980). Because of this, the frequently observed elevated mortality rates during the year after institutionalization essentially remain uninterpretable, and self-selection factors are the most plausible single explanation. Studies of aged individuals transferred from one institutional setting to another represent a better natural experiment then institutionalization in looking at the impact of environmental change. The impression is that earlier studies found such a transfer to be associated with increased mortality (Kasl 1972), whereas the more recent studies have consistently failed to do so (Kasl and Rosenfield 1980). Variations in the way the transfer process was handled may account for a good deal of this discrepancy, though differences in the quality of the new institutional environments and comparability problems between transferred and nontransferred subjects are plausible ad-

ditional explanations. It is also interesting to note that in several studies an anticipation effect was observed, that is, elevated mortality rates for a period prior to the move.

The work of Lieberman and his collaborators (e.g., Lieberman 1974, Tobin and Lieberman 1976) represents a prominent part of the institutionalization literature of the last 15 years. It is instructive to note that over the years this team appears to have become more skeptical of their ability to document the impact of institutionalization and tended to move toward the goal of understanding the predictors of adjustment and health outcomes, particularly in reference to institutional characteristics and personality variables related to successful adaptation. Thus, we remain unsure about the impact of institutionalization on the health of the elderly, but have become considerably more knowledgeable about the difficulties of studying this issue convincingly.

In the study of involuntary moves within the community, Fried's (1963) work on urban renewal remains an idealized paradigm: Residents in an old intact neighborhood, in which they had lived for many years and where rich and strong social ties exist, were forced out because of urban renewal or highway construction. They received no help with the move, they were scattered throughout the city, and they "grieve for their lost home." The early studies of relocation specifically dealing with the elderly have been mostly summarized by Niebanck (1968) and there would seem to be little doubt that some psychological distress was one of the consequences: depression, sadness, loneliness, insecurity. The impact on physical health was not documented and seldom studied.

Our recently completed prospective study of forced relocation (Kasl *et al.* in press) reflects the more current phenomenon: Elderly residents, living not in urban villages but in changing and deteriorating neighborhoods, are assisted to move into federally subsidized housing, which represents a residential improvement (structurally and socially) at a relatively favorable price. It may be an involuntary move, but in many ways it is also sought and desired. The overall results suggested that there were clear-cut benefits in the residential domain (e.g., perceptions of the dwelling and of the neighborhood) and that social interaction was not greatly affected, with any disruptions in social networks relatively easily repaired in the new setting. However, on indices of physical health status, those who were relocated did have more adverse outcomes than controls: more hospitalization events and nursing home admissions, greater incidence of stroke and angina pectoris, and poorer self-assessed health. Among those whose anticipatory perceptions of the relocation were more negative, the adverse health outcomes were more striking.

We have dealt selectively with some of the issues and studies of the

residential environment and health of the elderly. The greatest need is for adequately prospective studies in which self-selection factors are minimized and subjects are followed through the several (probably) stages of adaptation and impact. Adaptation processes themselves need to be studied more intensively and from a broad "person–environment fit" perspective. The study of residential changes in conjunction with other stressful life changes taking place would be also desirable. And the study of the impact of lack of residential mobility, in a setting of a changing and deteriorating residential situation, has been also neglected.

The Impact of Retirement on Health

The retirement and health literature poses a peculiar dilemma for the researcher. Unlike the usual situation, in which many studies dealing with a particular broad social influence on health are inconsistent and inconclusive, the health studies of retirement (and the researchers) are in remarkable agreement: The transition from work to retirement is not accompanied by an adverse impact (on the average) on physical or mental health status of the retiree (e.g., Atchley 1976, Friedman and Orbach 1974, Kasl 1980, MacBride 1976, Rowland 1977, Streib and Schneider 1971). The problem is that there is much in the scientific and political Zeitgeist that argues otherwise. Most notably, the whole stressful life events orientation ineluctably forces the "deduction" that retirement will have an adverse impact: see, for example, Camp's (1977b) recent review: "The sheer scope and pervasiveness of *changes* [in retirement] must forecast physical illness, according to the Holmes and Rahe paradigm [p. 149]." Similarly, "experts" dealing with the impact of work environments retain negative values and beliefs about retirement and cite unusual case histories of the devastating consequences following onset of retirement (e.g., Margolis and Kroes 1974). There is also the current political climate and recent legislation that seem to derive from an unquestioned social value that people should not be forced to retire and that it is beneficial for them to continue to work (protecting the financial integrity of the social security system may be an unspoken additional consideration).

Setting aside the issue of the cultural lag represented by the discrepancy between the Zeitgeist and the actual empirical evidence, in this section we wish to address three interrelated issues: How far can we push the conclusion that retirement has no (average) negative impact? How can this finding be best understood? What types of studies are needed to explore the limitations of this conclusion?

The general conclusion about the absence of a negative impact on health is based on results from a variety of studies using different designs and assessing mortality, morbidity, and self-reported health status. The findings are consistent even if no study by itself is immune from methodological criticism. Some studies suggest an improvement in health status after retirement, but they are all based on self-assessed health. Since the "improvement" was observed in physically demanding occupations and among workers whose health appeared to decline during their last work years, it is very likely that only the evaluation of health status improved after retirement, but not health measured by more objective criteria—if such had been also available.

Studies concerned with mental health and well-being have similarly failed to show an average adverse impact. Differences between the employed and the retired tend to wash out when one adjusts for age, health status, income, and functional disability. If adverse impact exists, it is probably in narrow domains, such as reduced perceived usefulness (Pack and Guptill 1966).

Understanding variations in postretirement outcomes is the obvious next concern, if the net, average effect of retirement appears to be nil. Here again, the transition from work to retirement appears to be rather unimportant. This is primarily because these variations in outcome are most convincingly seen as reflecting continuities of preretirement status, particularly in the areas of physical health, social and leisure activities, and general well-being and satisfaction. For example, George and Maddox (1977) found a very high temporal stability (r = .79) over a 6-year period on the Kutner morale scale.

Among the predictors of variations in postretirement outcomes, prior attitudes toward the process of retirement and expectations about postretirement outcomes have always looked promising. However, it appears that they make their contribution primarily via their association with underlying variables, such as prior health status and financial aspects of retirement. Thus they do not indicate the differential impact of retirement but rather reflect the continuities of powerful preretirement status variables.

Even variables reflecting aspects of the work role (such as job satisfaction and work commitment) do not appear to be strong and consistent predictors of variations in postretirement outcome. However, this is not yet a well-documented conclusion and in view of its counterintuitive nature, we should perhaps reserve judgment. The whole area of the occupational specificity of postretirement outcomes is not yet well studied and is a promising area of future explorations. For example, measuring degrees of work commitment among assembly line workers may

be a considerably inferior approach, compared with contrasting occupational groups that vary greatly in work commitment. Blue-collar and white-collar workers appear to go through different stages of adaptation to postretirement status, and this also appears a promising area for further investigations.

Financial considerations, in contrast to work role dimensions, appear to play a major role in the decision process and planning for retirement, in expectations about retirement, and in postretirement adjustment and well-being. Similarly, retired men who say they want a job or that they should have kept on working do so, to a large extent, for financial reasons (Kasl 1980). And the recent increase in the frequency of unfavorable feelings about retirement (Barfield and Morgan 1978) appears to be primarily due to the increased concern over inflation.

The notion that involuntary retirement among healthy employed individuals who wish to continue working may have adverse health consequences remains a viable hypothesis, in spite of the general negative evidence previously mentioned. This is because it has not yet been tested in a proper and adequately probing study design. Studying the effects of "mandatory" retirement among blue-collar workers who overwhelmingly wish to retire before the mandatory age (provided the financial benefits are adequate) fails to examine the hypothesis. Studying retired workers who wish to return to work primarily for financial reasons is at best studying the impact of inadequate financial circumstances, not of deprivation of the work role. And contrasting a cross-section of retirees who label themselves "voluntary" versus "involuntary" tends to load into the latter grouping those who are in poor health, who have had a more irregular work history (including recent layoffs or job loss), and who are in poorer financial circumstances. Once these powerful confounding influences are controlled for, there is little room for detecting the impact of the voluntary–involuntary dimension. Finally, we must recognize that even if the phenomenon of wishing to continue to work and not being able to because of forced retirement were quite uncommon (say, 1%) and strong adverse health effects among them not very frequent (say, 10%), we would still be dealing with a significant public health problem, since retirement is a near-universal experience for those in the labor force.

Given the ethical and practical limitations on social experimentation as well as the powerful self-selection factors that normally contribute to continuing to work beyond the usual retirement age, perhaps the best one can do is to take healthy individuals who experienced mandatory retirement at 65 and who miss work and would want to continue working, at least on a part-time basis. If the demand for such part-time jobs

exceeds the supply, such individuals could be randomly assigned to work versus no work conditions. Then the benefits of continuing to work beyond 65 could be evaluated fairly rigorously, particularly if the financial benefits were equalized for the two groups.

Social gerontologists have reminded us that retirement is not simply an event, but also a process (e.g., Atchley 1976, Carp 1977b). But when does the process begin and when does it end? Elsewhere (Kasl 1979) we have argued that perhaps for the majority of blue-collar workers in routine, uninteresting jobs, the significant adaptation process is not to retirement but to the particular work environment in which they find themselves. Moreover, this crucial adaptation (or failure to adapt) may take place decades before actual retirement, perhaps at the time when the worker comes to terms with the dull, monotonous job and gives up any expectation that work will be a meaningful human activity (Chinoy 1955, Kornhauser 1965). Under such circumstances, retirement (as the event of transition) should not be expected to have much of an impact.

There is another side to the argument, which also leads to an expectation of only an attenuated impact of retirement. Essentially, both on theoretical and intuitive grounds, the impact of the loss of the work role via retirement should be the greatest among those with strong job involvement, that is, high psychological importance of work to a person's total identity. Who are the people with strong job involvement? They have a stimulating job (high on autonomy, variety, task identity, and feedback), they participate in decisions affecting them, and they have a history of job success (Rabinowitz and Hall 1977). But they are also likely to be in jobs with greater power and prestige and to be themselves more privileged, socially and psychologically, with more resources to adapt to the transition, and in better physical and mental health. In short, the self-selection factors associated with strong job involvement, and thus a potentially greater retirement impact, are also factors that give the individual a greater capacity to withstand such an impact.

In view of the notable increase during the last 30 years in labor force participation of women, primarily white women (Sheppard 1976), it is useful to end this section with a brief comment on retirement studies of women. Even though the relevant evidence is much more limited compared with studies of men (Kasl 1980), there is no evidence to support the notion that for women who have worked, the work role has less significance than for men and that the impact of retirement is thus lessened. In fact, among the studies showing some sex differences, there was a hint that retired women were more likely to report difficulty adjusting to retirement than were retired men. However, the range of occupations used in these studies remains limited.

MEDICAL CARE BEHAVIOR OF THE ELDERLY

In this section, we wish to examine selected aspects of the broad research literature that deal with the determinants of contacts with the medical care system. The emphasis is on the elderly and on identifying meaningful age-related differences in the dynamics of such behavior. Of course, the experience of symptoms and self-appraisals of health status and disability are powerful partial determinants of medical care behavior, which are also age-related. However, our interest here is in the determinants that operate above and beyond the influence of differential health status. For this purpose, then, the usual data on age differences in doctor's visits or hospitalizations or medications are by themselves too ambiguous and will not be discussed.

The theoretical formulations that have been developed to formalize our understanding of this area are well outlined in Mechanic's (1978) chapter on "illness behavior." However, none of them deals explicitly with age, and the work that needs to be done is to collect systematic data on how age, as a nontheoretical variable, is to be linked to the various theoretical variables that are part of one or another of the formulations. A hypothesis regarding the effect of age that seems to have had a good deal of acceptance (e.g., Eisdorfer and Wilkie 1977) is the idea that serious illness is developmentally "on time" (in terms of the life-cycle) for an older person, thus mitigating its impact and the person's interpretation of it. However, it is not clear whether one can "deduce" from this that elderly subjects should respond with less denial and more readiness for appropriate medical care, or if they should show more apparent denial ("this isn't illness, but is part of getting old") and less readiness for medical care. The kind of finding showing that among the elderly there is an increasing discrepancy between physician evaluations and self-evaluations of health status with increasing age, thereby creating greater numbers of "health optimists" (Heyman and Jeffers 1963, Van Zonneveld 1969), is similarly ambiguous, suggesting either more denial or greater acceptance of illness because of a changing normative standard for self-evaluation. Comparing frequency of doctor's visits, which increase only slightly with age, with percentage with limitation in major activity due to chronic conditions, which increases very sharply with age (National Center for Health Statistics 1978), would seem to suggest inadequate medical care for such conditions among the elderly. However, this is only a crude interpretation, lacking any estimates of appropriate frequency of physician contacts for disabling chronic conditions and not discounting for the fact that acute conditions decline with higher age.

It is also interesting to note that in spite of the usual modest increase in doctor's visits with age (steeper for men), studies of very low users of free or prepaid medical services (Densen *et al.* 1959, Kessel and Shepherd 1965) reveal that older subjects (particularly older men) are overrepresented. This would seem to suggest that among older people (especially men) the above-average utilization rates hide two separate subgroups, those with increasingly frequent visits and those who continue their minimal contacts with the medical care system.

Given this theoretical and empirical complexity, it is difficult to prejudge the issue regarding the role of age in medical care contacts. Let us then look at some selected studies to see what picture emerges. We shall begin with treatment for high blood pressure because of its high relevance for the elderly.

In a recent review of studies dealing with community control of high blood pressure (Kasl 1978), the following picture emerges: The elderly are more likely to participate in blood pressure (BP) screening activities, particularly so in those that have normally a low yield, such as a letter inviting a visit to the clinic; the prevalence of previously "unknown" high blood pressure is lower among the elderly; the likelihood of being in current treatment among those with "known" high blood pressure is greater for the elderly; the likelihood of having blood pressure controlled for those in treatment is greater among the elderly; the success of referral from screening to a physician, among those who need such referral, is greater among older subjects. Overall, this is an impressive, consistent picture showing the elderly are more successful in the different phases of high blood pressure detection and control. Interestingly, these findings cannot be easily generalized to other areas of medical care.

Drawing on other reviews of the relevant literature (Becker 1974, Blackwell 1972, Kasl 1975, Marston 1970, Sackett and Haynes 1976, Wilson 1973), the following mixed picture emerges: Participation in free multiphasic health examinations is lower among elderly subjects and their attitudes toward such examinations are the most negative; compliance with medical care regimen and other recommendations does not bear a predictable or strong relationship to age—it is possible that the age group 45 to 65 has somewhat lower average compliance than other groups. However, a good deal of specificity of findings is in evidence: Premature termination from treatment for tuberculosis is more likely among older men and younger women; failure to keep appointments is not age-related; compliance with recommendations following executive health examinations is lower among older subjects; older subjects may have better compliance in severe disease situations such as classical

rheumatoid arthritis (Oakes *et al.* 1970) and chronic hemodialysis (Hartman and Becker 1978); weight reduction studies suggest elderly may remain longer as participants but have less success than the intermediate age categories; older age is not related (prospectively) to smoking cessation, even though older populations yield (cross-sectionally) more ex-smokers. Medication errors are seldom higher among older subjects and complexity of medication is the more important, underlying variable (e.g., Hulka *et al.* 1976). Attitudes toward physicians and medical services may be somewhat more negative among older subjects, especially black patients (Hulka *et al.* 1975). Anxiety about illness is not necessarily lower among the elderly; the elderly rather fear less the diseases of the young and the young fear less the diseases of the old (Levine 1962). Cancer is feared equally by the different age groups, but the elderly may show greater delay in diagnosis and treatment for cancer (Kutner *et al.* 1958). Older subjects have lower expectations of control over health matters (Kirscht 1972).

This is, indeed, a hodgepodge of findings! The intent is to illustrate the variety of findings regarding the influence of age on medical care behavior and to suggest that any crystallization of theoretical viewpoints regarding the role of age would be premature. For example, in the Health Belief Model (Becker 1974), the three major components that feed into "perceived threat of disease" are the importance of health, perceived susceptibility, and perceived seriousness. Do we understand how age influences these components? It is likely, for example, that age increases average perceived susceptibility, but what about seriousness? The reduced role demands in retirement suggest that one aspect of seriousness, interference with other role demands, may decrease. On the other hand, the perceived disability associated with a new chronic condition may increase with age, and the consequences of increased dependence on others may be more devastating to the elderly. Furthermore, since "threat of disease" may actually be curvilinearly related to readiness for medical care, it is also possible that elderly people function more often at the inflection point of the curve: Small increases in threat first increase and then reduce the readiness for appropriate action.

Overall, the success of high blood pressure control among the elderly remains unexplained by references to the other findings. Perhaps the at-risk role (Baric 1969), with all its ambiguities and indefinite time span, is easier for the elderly person to adopt; moreover, the "labeling" impact of being told of increased risk of disease in the absence of symptoms or distress may be lower among the elderly because of their different normative expectations about disease.

CONCLUSION

A consideration of the psychosocial forces that influence the health of the elderly in modern industrial society cannot escape the presumption of uniqueness of the elderly, which is so much part of our intellectual Zeitgeist. Aside from the presumably universal cultural practice of age-grading, there would seem to be at least three other circumstances that reflect and reinforce this presumption: first, the development of academic/scientific disciplines exclusively concerned with the elderly; second, the development of government programs and services targeted on the elderly; and third, the undeniable greater prevalence of adverse conditions among the elderly, particularly those involving economic factors and health status. Perhaps the most common consequence of these circumstances is the corollary presumption of the greater vulnerability of the elderly.

In this chapter, we have implicitly adopted the view that presumptions of the uniqueness and vulnerability of the elderly may be an obstacle to a dispassionate examination of the evidence. In fact, we would be comfortable with the general conclusion that the impact of psychosocial factors on health status is not dramatically altered by age. And when the evidence suggests that age does act to modify this impact, it is more often seen that the impact is weaker in the elderly than that it is stronger. This is perhaps counterintuitive and surprising, since there is much biological evidence suggesting that the elderly are less resilient to stresses, less physiologically adaptable, have showed homeostatic–regulatory functions, and are less immunologically competent (Finch and Hayflick 1977, Timiras 1972).

However, it is possible to offer a perspective that makes the above conclusion less surprising. This perspective suggests that the health of the elderly person, at any one point, can be seen as a cumulative function of the previous experiences, accumulated over a lifetime. Any new event comes to represent a diminishing fraction of this total accumulation of events and the impact thus diminishes proportionally. Of course, this is only a very global and incomplete statement of a perspective, and additional assumptions would have to be included and elaborated, such as: the process of prior attrition of the more vulnerable; accumulation of past learning facilitating adaptation to the next experience; reduced adaptive demands if societal role expectations become more open-ended; diminishing psychosocial significance of events because of life-cycle changes in aspirations, expectations, and perceptions.

The problem with the above perspective is that it can be reasonably

invoked after the fact, if the various results support it, but by itself, it has no compelling theoretical status and it cannot be an a priori guide to interpreting results. An opposite formulation would be equally convincing if the results favored it: namely, that the elderly are more vulnerable to the impact of various events and experiences because they come to draw on a diminishing or depleted reservoir of adaptive, equilibrium—restoring capability (Selye's reservoir of adaptive energy). The subthreshold impact of earlier years cumulates to become the suprathreshold health status change in the elderly.

While the evidence seems to favor the perspective of a diminishing impact of events and experiences on the health of the elderly, it would also seem that many of us are not comfortable with such a perspective. After all, the elderly seem to live in a state in which mounting social losses, physical debilitation, economic deprivation, and loss of (conventionally defined) useful work activities are taking place with great inevitability, but we do not seem to be able to detect the intuitively expected corresponding impact, such as in clinical depression or physical illnesses (Jarvik 1976). It is possible, then, that we have an incomplete grasp of the various positive factors in the lives of the elderly—the resources in their social environment, the adaptive strategies available to them—that serve to diminish the impact of the presumptively stressful experiences. Furthermore, we may not have a good understanding of what is specifically stressful to the elderly. That is, if we accept the approximate definition of stress as "demands that tax the adaptive resources," we may well ask if particular events and experiences represent social and personal demands equally for the elderly as for the younger person.

Overall, then, the biological and social sciences dealing with the elderly have accumulated valuable normative data on age-related changes in physiological functioning, health status, and their social conditions. However, these bodies of data cannot be easily juxtaposed to reveal the influence of psychosocial factors on the health of the elderly. We need in particular broader studies of so-called biological aging and secondary aging, which also include psychosocial factors, so that the role of these factors in aging can be assessed more directly.

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Financing the Health Care of the Aged

By JUDITH R. LAVE and HERBERT A. SILVERMAN

ABSTRACT: The Medicare and Medicaid programs, which were enacted through the 1965 amendments to the Social Security Act, placed the federal government in the central role of assuring access of the aged and the poor to needed medical care. In this article the trends in the sources of financing medical care services for the aged are examined. The distinction in terms of insurance coverage between acute care services and long-term care services is highlighted. The effect of the programs in terms of reducing the aged's direct financial cost of medical care, increasing their access to medical services, and improving their health status is explored. The unanticipated increase in the cost of these programs has led to a change in emphasis in public policy, from assuring access to mainstream medical care to containing the cost of providing care. The direction of new federal policies is analyzed, and it is concluded that no longer will it follow the private sector's specifications of the conditions and arrangements under which health services are provided to program beneficiaries.

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DURING the early 1960s, a growing body of research documented the exposure of the aged to the potentially ruinous costs of illness, especially if hospitalization was required. The 1963 Survey of the Aged by the Social Security Administration showed that only 51 percent of the aged had hospital insurance, and 43 percent had insurance for surgical services.[1] The survey also showed that those with insurance were admitted to hospitals at a rate more than 25 percent higher than those without, suggesting that lack of insurance presented a barrier to needed health care. The cumulating evidence and the growing concern about the devastating financial and social impacts on the aged, their families, and the community led to the enactment of the landmark 1965 amendments to the Social Security Act—the Medicare and Medicaid programs.

The major concern then was to provide the aged with access to the health services that were generally available to those who could afford to pay—that is, mainstream medicine—and to reduce the financial burden of illness. Implicit in the achievement of these objectives would be improved health for the aged and a better quality of life. These commitments to the aged have led to large and unanticipated increases in public expenditures, which now impose burdens on federal and state budgets that are no longer easily or willingly borne. Consequently there is now a reexamination of the premises that underlie the commitments made in 1965.[2]

1. Dorothy P. Rice, "Coverage of the Aged and Their Hospital Utilization in 1962: Findings of the 1963 Survey of the Aged," *Social Security Bulletin*, 27(7):9-28 (July 1964).

2. Although we focus here only on the aged, the same issues we present arise in the public financing of care for the disabled and the indigent.

In this article we examine some of the issues related to financing health care services for the aged. We begin with a brief overview of the major public sources of financing and then describe how the sources of funding for health care, in general and by specific services, has shifted since 1965. Next we assess whether Medicare and Medicaid were successful in meeting their initial goals of increasing the access of the aged to needed medical care and alleviating their financial burdens. We examine the unanticipated rate of increase in the costs of supporting these goals, and we discuss some of the steps being taken in recent legislation to constrain the rising costs of health care in public programs and their possible effects on providers and users of the services.

SOURCES OF PUBLIC FUNDING FOR THE AGED

There are a variety of sources of public funding for health services for the aged. State and local institutions provide some services. The Veterans Administration provides care to those with war-related injuries as well as to indigent veterans. These sources, however, are overshadowed by Medicare and Medicaid. Given the importance of these two programs, we shall discuss them in some detail.

Medicare

The Medicare program covers nearly all persons aged 65 and over, the disabled, and those with end-stage renal disease who meet the necessary qualifying conditions.[3] Approximately 26.5 million aged persons, or about 95 percent of all

3. For a more complete discussion of Medicare, see Kathryn D. Barrett, *Medicare: Persons*

the aged in the United States, are covered by Medicare.

Medicare consists of two separate but complementary insurance programs: Hospital Insurance (HI) for services furnished in hospitals, skilled nursing facilities, and home health services, and Supplementary Medical Insurance (SMI) for the services of physicians, home health visits—for those who are not covered under HI—out-patient services, and the costs of durable medical equipment and prostheses. Enrollment in HI is almost automatic upon turning 65, while enrollment in SMI is contingent on the payment of a premium.[4] Some services frequently used by the aged, such as out-patient drugs, dental services, and eyeglasses, are not covered. In short, Medicare was designed primarily to cover the major costs associated with episodes of acute illness.

There is some beneficiary cost sharing on Medicare-covered services. The cost-sharing provisions were included in the original legislation both to control federal budget costs and, more important, to deter unnecessary utilization. The actual cost-sharing provisions are complicated and vary from service to service. For example, for hospital care, the beneficiary must pay a deductible that is approximately equal to the cost of a hospital day, and he or she is liable for coinsurance from the sixty-first to the ninetieth day of hospitalization during the benefit period. For physician services the beneficiary must first meet a deductible and then is liable for at least 20 percent of the physician's charge. Medicare beneficiaries who are also covered by Medicaid are exempt from these cost-sharing provisions.

To gain the cooperation of the providers, Congress incorporated into the Medicare legislation many of the standard features of the Blue Cross/Blue Shield plans—then the dominant form of private health insurance. The most important features included beneficiary freedom of choice of providers, cost-based reimbursement for institutional providers, and fee-for-service reimbursements—based on local charges—for physicians. There were few limitations on the use of covered services.

Medicaid

Medicaid, a program to provide medical services to the poor, is administered by the states under federal guidelines. With respect to the aged, Medicaid pays for medical care for those aged who meet the Supplementary Security Income (SSI) eligibility standards.[5] In fiscal year 1979 approximately 3.4 million people

Enrolled in Health Insurance Program, 1978-1979, HCFA pub. no. 03142 (Baltimore, MD: Health Care Financing Administration, 1982).

4. The Medicare HI and SMI programs are financed from separate trust funds. Revenues for the HI trust fund are derived principally from payroll taxes on employed workers and their employers and from self-employed persons in covered work. SMI premiums are paid for each enrollee. States may pay premiums on behalf of aged Medicaid recipients, thereby buying into SMI. In 1979 about 2.5 million of the 24.1 million aged SMI enrollees were buy-ins. The revenues derived from enrollee premiums are supplemented by contributions by the federal government from general revenues. Originally beneficiary premiums were to provide half of the SMI revenues. Subsequent changes in the formula for computing the premium have resulted in general revenues accounting for about 70 percent of the income required for the coverage of SMI benefits to the aged.

5. For a discussion of the groups eligible to receive Medicaid benefits and of the benefits furnished under the program, see Donald N. Muse, *National Annual Medicaid Statistics: Fiscal Years*

over 65 had some services paid for by Medicaid. For dually eligible recipients, Medicare is the first payer for Medicare-covered services, and Medicaid is the second payer; that is, Medicaid will pay the cost-sharing amounts that would normally fall to the patient. Depending on the state's program, Medicaid may also pay for the cost of services not covered by Medicare, such as out-patient drugs and optical and dental services. More important, as Medicare fulfilled its purpose of covering most of the health care costs related to episodes of acute illness, Medicaid has evolved into the primary public source of funding for long-term nursing home services for the aged.

PAYMENTS FOR HEALTH CARE SERVICES TO THE AGED

Health care services can be paid for from either public or private funds. If paid for privately, payments may be made directly by patients or their families to the providers or indirectly through insurance purchased by the individual. Recent data indicate that 61 percent of the aged have some private health insurance policies.[6]

As shown in Table 1, total health care expenditures for the aged were $8.9 billion in 1965 and had increased to $49.4 billion in 1978, the latest year for which age-specific data are available. In 1965 70 percent of the expenditures for health services to the aged were financed by private funds. By 1978 only 36.8 percent were privately funded. It is not surprising that, given the benefit structures of the Medicare and Medicaid programs, the split between public and private financing varies considerably by type of expenditure: 87.5 percent of hospital expenditures, 59.4 percent of physician expenditures, and 46.2 percent of nursing home expenditures were financed by public programs. The sources of private expenditures vary by type of service. As may be derived from Table 2, private insurance covers 60 percent of the beneficiaries' private liability for hospital care, 37 percent of their private liability for physicians' services, and only 3 percent of their private liability for other services, the largest of which is nursing home care.

Most of the private insurance held by the aged is purchased to cover the gaps in reimbursement for Medicare-covered services and not to cover the costs of services not included under Medicare. Thus many persons over 65 avoid much of the out-of-pocket expenditure contemplated under the copayment provisions of the Medicare law. For several reasons we believe it is unlikely that there will be any significant expansion of private insurance to cover these other uncovered services, such as drugs, dental care, and eyeglasses, used frequently and by most of the elderly. But the average expenditure for these services is fairly low and predictable and, for most of the elderly today, can be budgeted. The administrative costs of servicing policies insuring these items would be high relative to the benefits paid. Hence it would not generally be worthwhile to

1973 through 1979, HCFA pub. no. 03133 (Baltimore, MD: Health Care Financing Administration, 1982).

6. Larry Corder and Allen Dobson, "Health Care Coverage Estimates from the National Medical Care Utilization and Expenditure Survey: February to April 1980" (Report presented to the American Public Health Association, 109th Annual Meeting, Los Angeles, CA, 1-5 Nov. 1981).

TABLE 1
DISTRIBUTION OF PERSONAL HEALTH EXPENDITURES BY PERSONS AGED 65 YEARS AND OVER, BY TYPE OF EXPENDITURE AND SOURCE OF FUNDS, 1965 AND 1978

Type of Expenditure	EXPENDITURES (millions of dollars)						PERCENTAGES					
	Total	Private*	Public				Total	Private*	Public			
				Medicare	Medicaid	Other†			Total	Medicare	Medicaid	Other†
1965												
Total	8,839	6,213	2,656	–	–	2,656	100.0	70.0	30.0	–	–	30.0
Hospital Care	3,296	1,677	1,619	–	–	1,619	100.0	50.9	49.1	–	–	49.1
Physicians' Services	1,737	1,617	120	–	–	120	100.0	93.1	6.9	–	–	6.9
Dentists' Services	213	201	12	–	–	12	100.0	94.7	5.6	–	–	5.6
Other Professional Services	244	236	8	–	–	8	100.0	96.7	3.3	–	–	3.3
Drugs & Drug Sundries	1,148	1,030	118	–	–	118	100.0	89.7	10.3	–	–	10.3
Eyeglasses & Appliances	256	254	2	–	–	2	100.0	99.2	0.8	–	–	0.8
Nursing Home Care	1,825	1,187	638	–	–	638	100.0	65.0	35.0	–	–	35.0
Other Health Services	150	13	137	–	–	137	100.0	8.7	91.3	–	–	91.3
1978												
Total	49,366	18,192	31,175	21,775	6,611	2,789	100.0	36.8	63.2	44.1	13.4	5.7
Hospital Care	21,169	2,645	18,524	15,799	754	1,971	100.0	12.5	87.5	74.6	3.6	9.3
Physicians' Services	8,910	3,620	5,290	4,954	260	76	100.0	40.6	59.4	55.6	2.9	0.9
Dentists' Services	1,383	1,338	45	–	34	11	100.0	96.8	3.2	–	2.4	0.8
Other Professional Services	1,090	631	459	381	72	6	100.0	57.9	42.1	35.0	6.6	0.6
Drugs & Drug Sundries	3,231	2,728	503	–	468	35	100.0	84.4	15.6	–	14.5	1.1
Eyeglasses & Appliances	605	405	201	189	–	12	100.0	66.9	33.2	31.2	–	2.0
Nursing Home Care	12,824	6,790	5,834	380	4,969	485	100.0	53.8	46.2	3.0	39.4	3.8
Other Health Services	354	35	319	72	54	193	100.0	9.9	90.1	20.3	15.3	54.5

SOURCE: Charles R. Fisher, "Differences by Age Groups in Health Care Spending," *Health Care Financing Review*, 1(4):65-90 (Spring 1980).

*Includes expenditures by individuals' private insurance, philanthropic organizations, and industrial in-plant health services.

†Includes expenditures by the Veterans Administration, state and local hospitals, workers' compensation, and other federal, state, and local programs.

TABLE 2
PERCENTAGE DISTRIBUTION OF HEALTH CARE EXPENDITURES BY THE AGED, BY TYPE OF SERVICE AND CHANNEL OF PAYMENT, CALENDAR YEAR 1977

		SOURCE OF EXPENDITURE				
	Total	Private				Public
Type of Service		Total	Direct Payment	Private Health Insurance	Other	
All Personal Health Care	100	36.1	29.1	6.6	.4	63.9
Hospital	100	12.0	4.6	7.1	.3	88.0
Physicians	100	41.8	26.2	15.5	–	58.2
Other	100	60.6	58.0	1.9	.7	39.4

SOURCE: Fisher, "Differences by Age Groups in Health Care Spending."

purchase insurance to cover the routine costs of these services.

Insurance to cover the costs of long-term care in nursing homes has failed to develop for quite different reasons. Long-term nursing home care has attributes that distinguish it from other medical services. It is focused less on the provision of medical care for an illness and more on providing the basic needs of daily living—feeding, bathing, caring—for those who can no longer care for themselves. Many of the services provided by nursing homes are those that have been traditionally provided by family and friends. In fact it has been estimated that for every five aged persons in a nursing home there are four more living in the community, who "have levels of functional disability so high that they require direct personal assistance in performing even the most basic activities of daily living."[7]

There is, therefore, considerable discretion in deciding when to seek long-term nursing home services. In addition, once people begin to use long-term nursing home services, the likelihood is very strong that they will continue to do so. Private insurance to cover the costs of these services would be expensive, probably prohibitively so. Since there is a large element of discretion in the decision about when to seek nursing home placement, the purchase of insurance to cover its costs could be timed to coincide closely with actual use. This element of adverse selection would be reflected in the premiums. Consequently insurance for nursing home care is rare and is unlikely to become more prevalent. The cost of long-term care services not paid for by Medicare or Medicaid, particularly nursing home care, is likely to remain the direct responsibility of the aged and their families.

7. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Working Papers on Long-Term Care" (Unpublished, DHHS, Washington, DC, 1981).

THE ACHIEVEMENTS OF THE PUBLIC PROGRAMS

Implicit in the initial goals of Medicare and Medicaid was the assumption that they could be achieved at a reasonable cost. In this section we consider the extent to which these goals were met. In

the next section we shall discuss the costs of these programs.

Reduction of financial burden

The data presented earlier show that as a result of Medicare, the elderly are no longer exposed to the high costs of hospitalization. The costs of physician services, too, are largely covered. The average aged person is, therefore, protected against the potentially catastrophic financial costs associated with acute illness episodes, particularly those requiring hospitalization.

The protection provided by Medicare becomes more apparent when the distribution of benefits is examined. In 1978 only 4.8 percent of the aged enrolled for Medicare received reimbursements of $5000 or more, but they accounted for 53 percent of all Medicare reimbursements on behalf of the aged.[8] Furthermore, in a given year about 28 percent of all Medicare reimbursements on behalf of the aged are for persons in their last year of life.[9] Thus the major portion of Medicare benefits go to the relatively small number of the insured who incur high medical expenses, many of whom die within the same year.

Though Medicare provides protection against the costs of acute illness, the aged and their families continue to carry the primary responsibility for long-term nursing home costs. Because of the likely duration of the need for these services and the costs, the states, through the Medicaid program, often assume responsibility for their costs for the indigent aged, or for the aged who have become impoverished through paying for these services. In 1978 Medicaid covered 39.4 percent of the nursing home expenditures of the aged. Private sources, mostly the aged person and/or the family, paid 53.8 percent of nursing home costs.

Another way of measuring the achievement of the public programs is to examine the proportion of income that the aged spend on health services. In 1979 the estimated per capita out-of-pocket expenditure by the aged for health services, including the cost of premiums for coverage under the Medicare SMI program and for private insurance, was $754, or 12 percent of an average per capita income of $6270. In fiscal year 1966, the year prior to implementation of the Medicare and Medicaid programs, the aged spent 15 percent out-of-pocket on health services. The data point to a decrease in the direct financial burden on the aged for the cost of health care services.

Access to care

As a result of increased public funding for Medicare, access by the aged to the health care system appears to have improved. Since the introduction of Medicare, utilization of medical services, particularly of hospital services, by the aged has increased. Hospital admission rates for the aged began to increase after the implementation of the program

8. Bennett Hirsch, Herbert A. Silverman, and Allen Dobson, *Medicare Summary: Use and Reimbursement by Person, 1976-1978*, HCFA pub. no. 03137 (Baltimore, MD: Health Care Financing Administration, 1982).

9. James Lubitz and Ronald Prihoda, "Use and Costs of Medicare Services in the Last Years of Life," *Health Care Financing Review* (in press); Martin Ruther, *Medicare: Use of Short-Stay Hospitals by Aged and Disabled Inpatients, 1978*, Program Statistics Series (Baltimore, MD: Health Care Financing Administration, forthcoming).

and have continued to rise ever since at a rate higher than that of the general population. Increased admission rates have been experienced by all the older age groups. There has been a concomitant increase in the use of physician services, such as surgeries, within hospitals. Although the data do not show an increase in the number of physician visits per capita, they do suggest that the intensity of services provided by physicians has increased—for example, laboratory tests and X rays.

Even more important than the overall increase in utilization rates has been the marked reduction in racial and income-related disparities in the use of physician and hospital services. The observed difference in hospital use by insurance status—highly related to income—was one of the important factors giving impetus to the enactment of the 1965 amendments. Analysis of program use in 1969 suggested that utilization was still strongly influenced by income and race.[10] By the mid-1970s many of these differences had disappeared.[11] While not all of the change in relative utilization can be attributed to the success of the public programs, surely some of it can.

Improved health status

Have improved access to and increased use of medical services improved the health of the elderly and the quality of their lives? Evidence on this is scant. There has been a decrease in the age-adjusted mortality rates for both men and women over 65. The decrease between 1968 and 1977 was significantly greater than that between 1955 and 1967, and Hadley has suggested that this is partially attributable to the increased utilization of health care induced by Medicare.[12] He found that a 10 percent increase in per capita use of medical care is associated with about a 1.5 percent decrease in mortality rates. Finally, there has been an increase in many procedures, such as cataract extraction and artificial hip replacements, and improvements of cardiac functioning provided by new surgical procedures and pacemaker implants, which have no doubt improved the quality of life for many of the elderly. We doubt that much of this would have taken place without the resources made available and the access provided by the public programs.

It must be pointed out that the relationship between increased health expenditures and increased health status remains controversial. The efficacy of many procedures has not been thoroughly evaluated, iatrogenic problems exist, and there is suspicion that many expenditures, on the margin, have had no beneficial effect.[13]

THE COSTS OF THE PROGRAMS

It is clear that, on balance, Medicare and Medicaid have been successful in

10. Karen Davis and Roger Reynolds, "Medicare and the Utilization of Health Services by the Elderly," *Journal of Human Resources*, 10(2):361-77 (Summer 1975).

11. Martin Ruther and Allen Dobson, "Equal Treatment and Unequal Benefits: A Reexamination of the Use of Medicare Services by Race, 1967-1976," *Health Care Financing Review*, 2(3):55-83 (Winter 1981); Charles R. Link, Stephen H. Long, and Russell F. Settle, "Equity and the Utilization of Health Care Services by the Medicare Elderly," *Journal of Human Resources*, 17(2):195-212 (1982).

12. Jack Hadley, *More Medical Care, Better Health?* (Washington, DC: Urban Institute, 1982).

13. John E. Wennberg, John P. Bunker, and Benjamin Barnes, "The Need for Assessing the Outcome of Common Medical Practices," *Annual Review of Public Health*, 1:277-95 (1980).

meeting their original objectives. Yet it is apparent from the lively debates in Congress and in the states that these programs are perceived as mixed blessings, having become part of the fiscal shoals on which state and federal budgets are foundering.

As Table 1 shows, personal health care expenditures of the aged increased from $8.9 billion in 1965 to $49.4 billion in 1978, an average annual increase of 14.1 percent.[14] The surge was led by the new monies from Medicare and Medicaid. From 1967 through 1978, expenditures for services to the aged by Medicare increased at an average annual rate of 15.7 percent, to $21.1 billion. From 1978 to 1981 the rate of increase accelerated even further, to 19.4 percent per year, resulting in estimated expenditures of $28.5 billion. Medicaid shows a similar pattern. From fiscal year 1973 through fiscal year 1978 Medicaid expenditures for the aged increased at an average annual rate of 14.9 percent, to $6.4 billion. In fiscal year 1979 the rate of increase in Medicaid expenditures for the aged accelerated to 20.3 percent over fiscal year 1978, to $7.7 billion. Preliminary estimates indicate a continuation of this pace.

As a result of these rapid rates of growth in Medicare and Medicaid, projected expenditures for health programs constituted 10.1 percent of the 1982 federal budget, the fourth largest item after national defense, income security, and interest on the national debt. Of the projected increase in federal health expenditures of $8.6 billion over 1981, all but $0.3 billion were for Medicare and Medicaid. Clearly the containment of Medicare and Medicaid expenditures is essential to controlling the rise in public expenditures.

14. Hirsch, Silverman, and Dobson, *Medicare Summary*.

POLICY CHANGES

Problems of financing health care for the aged today are quite different from those of 1965. Although the costs of long-term nursing home care constitute the major remaining source of potentially catastrophic expense to the aged and their families, it seems unlikely that the Medicare benefit structure will be expanded to include these services as an entitlement of program beneficiaries. It is also unlikely that Medicare will be expanded to include other noncovered services, unless there is strong evidence that the costs of doing so will be offset by savings from reduced use or costs of currently covered services. In short, major legislative and policy changes will be directed at reducing, if not actually eliminating, the rate of cost increase in Medicare and Medicaid.

There are a number of different approaches to reducing the costs of the Medicare and Medicaid programs. These include the following:

—decreasing the size of the eligibility groups;

—changing the nature of services covered to try to encourage a more efficient use of services;

—decreasing the level of reimbursement to providers, and monitoring the use of services more closely;

—increasing beneficiary liability directly by increasing the size of the SMI premium, the coinsurance rates, and the deductibles; and

—trying to increase the efficiency of the overall health services delivery system.

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In this section we examine some of the proposed applications of these approaches to containing the costs of hospital services under Medicare and the costs of nursing home services under Medicaid. In doing so we stress some of the choices that must be made and examine some of the provisions of recent legislation to highlight the directions in which public policy seems to be heading.

Medicare: hospitals

As noted earlier, the premises governing the coverage of hospital services under Medicare included reimbursement of the hospital's incurred costs in providing services to Medicare patients; small cost-sharing requirements for patients, which were often avoided through the purchase of private complementary insurance; and freedom of choice in the selection of the place of treatment. It quickly became apparent that these basic premises did not provide incentives to either patients or providers to make the most efficient use of hospital resources. Limited coinsurance for patients permitted them to use hospital services, no matter what the cost, as long as there was hope of improving health status or alleviating discomfort. Freedom of choice, coupled with limited coinsurance, permitted patients to use high-cost providers with no direct cost to themselves. Cost reimbursement imposed no penalty on hospitals for inefficiency, nor any reward for efficiency. These arrangements underlay the rise in hospital costs for Medicare and spilled over to affect all other users of hospital services, leading to a reexamination of the bases for reimbursing hospitals and to a search for alternative payment arrangements that would arrest the rise of program expenditures for hospital services.

The following simple equation provides a useful framework for thinking about the factors leading to the rising expenditures for hospital services and the dilemmas presented by some of the options being considered to change the basis for paying for them:

$$\text{Total cost} = \text{Population} \times \frac{\text{Services}}{\text{Population}} \times \frac{\text{Price}}{\text{Service}}$$

That is, the program's total cost for a particular type of service during a particular period of time is the product of three factors:

1. Population: the number of persons who are potential users of the services. Those enrolled in a given year for Medicare would be the population of interest with respect to the costs to the Medicare program.

2. Services/Population: the average number of units of service used per member of the population of interest. For hospital services this would be measured as days of care per enrollee.

3. Price/Service: the average unit cost for a particular type of service. For hospital services this would be measured as Medicare reimbursement per day of care.

To reduce Medicare hospital expenditures—and this applies equally to any type of service and, by summation, to the program as a whole—or the rate of increase in those expenditures, policymakers could change the growth in the eligible population, change the rate of use of the services, or reduce the amount the program pays for a unit of service. By discussing some of the interrelationships among these factors with respect to financing the cost of short-stay hospital services under Medicare, we illustrate some of the policy alternatives and dilemmas facing Medicare in general.

TABLE 3
FACTORS IN MEDICARE EXPENDITURE INCREASES, 1967-78

FACTOR	PERCENTAGE CHANGE	
Population	+12.0	
Utilization	+ 1.9	
Discharge rate		+13.9
Average length of stay		−12.0
Reimbursement per day	+86.1	
General inflation		+40.5
Hospital market basket increase above the general inflation rate*		+ 9.1
Intensity of services		+36.5
Total		100.0

SOURCE: Martin Ruther and Herbert Silverman, "Medicare Reimbursements for Short-Stay Hospital Services, 1967-1978," in Ruther, *Medicare: Use of Short-Stay Hospitals.*

*For a discussion of the hospital market basket concept, see Mark Freeland, Gerard Anderson, and Carol Ellen Schendler, "National Hospital Input Price Index," *Health Care Financing Review,* 1(1):37-61 (Summer 1979).

In Table 3 analysis of data for 1967-78 shows the contributions made by these factors to increases in Medicare expenditures for hospital services to the aged. The contribution made by population growth represents the net increase of Medicare enrollment due to the difference between the rate of eligible persons attaining age 65 and the death of current enrollees. The average increase has been about 2 percent per year. No serious proposals have been made to change the bases for Medicare eligibility, though there has been some discussion of increasing the retirement age to 68. The relatively small contribution made by the increased rate of use of short-stay hospital services results from offsetting trends in the discharge rate and the average length of stay.

The major factor in increased expenditures for hospital care is the increased cost per day. The major share of this increase was attributable to effects of the general price inflation in the economy and the rise in the price of the inputs used by hospitals to furnish a day of care. However, a substantial portion of the increase was attributable to the increased intensity of services furnished during a hospital day—more tests, more X rays, more complex technology, and increased level of hospital staffing. Increased intensity of services is a problem not only because of its direct effect on Medicare expenditures, but also because of doubt that it results in either improved patient care or better health outcomes; in short, the assumption is that value is not being received for the money. Whatever the sources or the justifications for the rising costs of hospital care, given the reimbursement principles incorporated in the 1965 amendments, the rising costs passed almost directly to the program. Contemplated changes in the reimbursement arrangements usually have two facets: (1) they shift more of the costs to the patient, and (2) they put

some kind of cap on what the program would pay to the hospital.

Shifting costs to the patient

The patient now pays only a deductible, approximately equal to the cost of the first day of hospitalization, and Medicare picks up all covered costs through the sixtieth day. Coinsurance payments are required for up to the next 30 days, but few beneficiaries reach that point. One frequently mentioned approach to increased cost sharing by the patient is the imposition of a daily coinsurance payment for a specified number of days after admission. The coinsurance could be a flat per diem amount, or a percentage of the hospital's charges. This presumably would increase patient awareness of the costs of care. Cost consciousness could result in greater patient concern about the length of stay or about the level of charges. In both cases program costs would be reduced. The proposal is supported by those who believe that if Medicare beneficiaries were made more aware of costs they would make more cost-conscious decisions, and the effect would be to increase price competition among hospitals. Others question the extent to which a sick elderly patient could make such economic decisions when facing the prospect of hospitalization.

One effect of increased cost sharing is likely to be an increase in the cost of Medigap insurance policies, and many would have to discontinue such insurance. We believe it is more likely that the aged would continue to want to put limits on the extent of their out-of-pocket liabilities and would make strong efforts to retain complementary coverage despite increased premium costs. This would dilute, as it does now, the effects of the increased hospital cost-sharing measures recently enacted or now contemplated, and it would minimize their expected effects on the efficiency of the hospital system.

Limiting Medicare payments to hospitals

Proposed methods of limiting Medicare payments to hospitals range from a negotiated flat sum for all Medicare patients treated by the hospital to prospectively specified, per-case reimbursements based on diagnosis. Both types of caps would make hospital administrators more conscious of the price and quantity of the resources used to provide care. As previously noted, almost 37 percent of the rise in Medicare expenditures for hospital services between 1967 and 1978 was due to increased intensity of care. Advocates of prospective reimbursement limits say that hospitals will be forced to weigh more consciously the costs and benefits of additional resources in the provision of care. This can only increase hospital efficiency. Opponents argue that the quality of care would suffer and that hospitals would try to divert patients with complicated and expensive-to-treat conditions to other hospitals.

The effect of the Medicare caps would also depend on whether other third-party payers follow Medicare's lead. If Medicare reimbursement levels are set below those of private payers, some hospitals may choose to withdraw from participation in the Medicare program or to remain only if they can bill patients for amounts beyond what is paid by Medicare. Some patients may protect

themselves against this extra billing by purchasing additional insurance. Other beneficiaries will find that their choices are more restricted or that they are more liable for out-of-pocket costs if they insist on going to the hospital of their choice.

Medicaid: nursing home costs

While inflation in the economy made the major contribution to rising Medicaid nursing home costs, changes in the age composition of the elderly added significantly to the upward pressures on these expenditures. Between 1966 and 1981 Medicare enrollees aged 85 and over more than doubled, from 1.2 million to 2.5 million. Their proportion of the Medicare enrollment increased from about 6 percent to almost 10 percent, and they are the group most likely to be in need of long-term nursing home services.

States have directed more attention than Medicare to controlling the size of the eligible population, by tightening the income/assets criteria for eligibility. In addition the states have placed constraints on the rate of building nursing home facilities and on the increase in nursing home reimbursements. Nevertheless, given the continued growth and increased aging of the elderly population, total expenditures for long-term nursing home services are likely to continue their inexorable climb.

Legislative efforts to control costs

The first serious legislative efforts to control the rise in Medicare and Medicaid expenditures were made by the Social Security amendments of 1972. Among the cost-control measures were an increase of the Medicare SMI deductible; the establishment of professional standards review organizations (PSROs) to review the medical necessity and appropriateness of institutional services covered under federal programs; restricting increases in prevailing physicians' charges—that is, maximum allowed—to increases in the cost of practice and in the general earnings level in the physicians' service areas; requiring that providers obtain the approval of local and state health planning agencies for all capital expenditures exceeding $100,000 as a condition for including their costs in Medicare and Medicaid reimbursements; authorizing Medicare to contract with health maintenance organizations (HMOs) to provide Medicare-covered services on a capitation basis; allowing the states to impose copayment requirements on the medically needy Medicaid recipients; and authorizing experiments or demonstration projects to develop methods for paying providers of services on a basis other than cost reimbursement.

These were considered to be bold departures from the premises of the 1965 amendments. The HMO provisions, and the support subsequently given by the government to their development, represented the first effort of alter the structure of the health services delivery system to make it more cost-effective. The authorization for experimenting with methods of prospective reimbursement of hospitals and other providers signaled government's readiness to move away from cost reimbursement.

If these measures had any significant effect on program cost trends, they were not apparent from the experiences of the

subsequent years: Medicare and Medicaid expenditures continued to grow at unacceptably high rates. Recent legislation indicates that Congress and the administration are ready to move even further from the premises of the 1965 legislation.

The Omnibus Budget Reconciliation Act of 1981 increased the SMI deductible, increasing beneficiary cost sharing. Perhaps most fundamental was its authorization for restricting Medicare recipients' freedom to choose among providers, practitioners, and suppliers of health services.

The Tax Equity and Fiscal Responsibility Act of 1982 continued the major changes to Medicare and Medicaid that dilute and alter some of the basic premises of the 1965 legislation. First, the act allowed further redistribution in the way in which payments for services used by aged Medicare beneficiaries are to be apportioned among the program, beneficiaries and employers:

1. Employers of 20 or more employees must cover employees and their spouses between 65 and 69 years of age under the employer's health plan, if there is one. Although the services used are covered by Medicare and the employee remains entitled to Medicare, the employer's plan would be first payer for services covered by the plan.

2. The SMI premium and the HI deductibles were increased.

3. Program reimbursements for hospital-based physicians and most hospitals were lowered, as was the reimbursement for many hospital-based nursing facilities and home health agencies.

Second, the act provided a new Medicare benefit, hospice care for the dying, expecting that its availability would reduce the use of higher-cost hospital and nursing home care and would reduce total program expenditures. Third, the act changed the reimbursement arrangement available to HMOs to make it more attractive for them to enroll Medicare beneficiaries and thus promote competitive alternatives to the fee-for-service sector. Fourth, the act modified Medicare utilization review programs by establishing peer review organizations and by increasing their independence from the providers whose services they review.

The Social Security amendments of 1983 introduced further reform into hospital reimbursement. Prospective payment based on case type is to be phased in over the three-year period beginning 1 October 1983.

CONCLUSION

The 1965 amendments placed the federal government in the central role of assuring that the aged and the poor would not be barred by costs from medical services needed for the treatment of illness. The inevitable question is, What have the 1965 amendments, taken together, achieved?

For the aged and their families, the programs have led to a decrease in the personal cost of care, increased access to and utilization of services, and possibly some overall improvement in their health status. By provisions of the law and the administration of the program there are virtually no barriers to necessary hospital care. By purchasing complementary insurance most aged Medicare beneficiaries have protected themselves against major expenses that could arise under its cost-sharing provisions. The elderly and their families still carry initial and primary responsibility for the costs of long-term nursing home care.

For Medicare and Medicaid the result was a rise in expenditures of a rate and magnitude that were unanticipated. For Medicare the increase was led by rapidly escalating costs of hospital care; for Medicaid it was led by the rise in the aged nursing home population and the costs of nursing home services. Increased expenditures required by these programs contributed materially to the increased pressures on federal and state budgets, leading to a series of legislated changes designed to contain their rising costs. We have identified five broad courses of action that have been taken to achieve this objective.

If measures already taken do not result in an early abatement in the rise of Medicare and Medicaid expenditures, pressures will increase to develop a capitation system in Medicare. Enthoven's health plan is the best developed of the proposed systems.[15] The essence of the plan is to give Medicare beneficiaries a voucher that would allow them to choose among a set of approved plans for the services to which they are entitled under Medicare. Most of these plans are expected to be of the HMO-type. The amount of the voucher could be limited, and increases in program outlays could be controlled by indexing the amount of the voucher to some indicator. It is not likely that such a system will be implemented soon. Nevertheless if Medicare expenses continue to rise as rapidly as the increases in out-of-pocket costs to the elderly, it is likely to attract more attention.

The types of changes that have already been or are likely to be enacted in the future suggest that federal and state governments are no longer following the private sector's specifications of the conditions and arrangements under which health care services are to be furnished to program beneficiaries. Medicare and Medicaid will continue to subsidize the care for the elderly and the poor. No longer, however, are access to mainstream medicine and freedom of choice considered to be sacrosanct criteria.

If the changes already enacted in Medicare and Medicaid significantly reduce the rising curve of public expenditures for health care services, they will have to do so in the face of countervailing demographic trends. The elderly who have been particularly prone to the need for long-term nursing home care—those 85 and older—have been growing at a rate triple that of the other aged groups. If current proposals to cut Social Security benefits are enacted, as more of the costs of health services are shifted to program beneficiaries the aged entering nursing homes are likely to be less well-off than those in recent years. The costs of long-term nursing home care are high and can extend over a long period of time. The probability of aged nursing home residents exhausting their financial resources and resorting to Medicaid to cover the costs of continued care appears likely to grow. Thus any savings in public programs from recent changes in the conditions under which such programs cover costs of acute illnesses could be offset by the inexorable growth in the number and the needs of the aged requiring long-term nursing home care.

This country is in the midst of reexamining the role of public programs in carrying out intergenerational obligations. The Social Security legislation of the New Deal in the 1930s established much of the basic framework for govern-

15. Alain C. Enthoven, *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care* (Reading, MA: Addison-Wesley, 1980).

ment involvement in what had traditionally been family responsibilities. The Great Society legislation of the 1960s greatly expanded government's role, most notably by the enactment of the Medicare and Medicaid programs in 1965.

Since the 1972 Social Security amendments Congress has indicated its unwillingness to maintain an open-ended financial commitment to the obligations undertaken in 1965. The current discussion in Congress and in the administration concerning the fiscal viability of the old-age and survivors' income insurance program indicate an emerging consensus that the amounts paid in benefits have to be conditioned on the amounts collected in payroll taxes, and that the latter, in turn, are conditioned by the need for a growing economy. Therefore it seems to us to be only a matter of time before the scope and the division of public and family responsibilities for assuring the daily care of the aged are reexamined.[16]

16. This conclusion was written before the DHHS distributed a special supplement to the Medicaid manual, indicating that states can require adult family members to support adult relatives. "Family responsibility laws" have been passed or are under consideration in several states.

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Universally insured medical and hospital services provided the opportunity to trace the health care utilized by a large probability sample of elderly residents of Manitoba, Canada. The findings suggest that most elderly are healthy and that they are low, infrequent users of services. A minority were identified who are very high users of health care. The potential influence of physician discretion and of the growth in the number of physicians on the utilization patterns of the elderly are discussed.

Key Words: Aging, Longitudinal studies, Health services research

Aging and the Demand for Health Services: Which Aged and Whose Demand?[1]

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The topic of patterns of health care utilization by the elderly is currently arousing increased concern and interest among researchers. High health care costs, the disproportionate share of resources consumed by the elderly, and the expanding size of the elderly population have all contributed to this interest. Figure 1, taken from a recent Statistics Canada publication (1980b), focuses on the reason for this concern: the elderly use a very high proportion of hospital days, and hospital days are the most expensive resource in the health care system. In 1977, 9% of the population (those aged 65 and over) consumed 43% of all acute hospital days (Statistics Canada, 1980b). Figures from the United States are similar; in 1978, 11% of the population (those aged 65 and over) used 36% of all short stay hospital days (Vital and Health Statistics, 1980).

Hospital usage rises dramatically with age. The 85 and older group consume approximately 10 times as many hospital days as any of the age groups under 60, while the 70-year-olds consume only about three times as many. These usage patterns, combined with the projected increase in the very elderly population over the next two decades, has created a sharp interest in aging and the demand for health services.

Research under way in Manitoba, however, suggests that important, nonobvious aspects of health services utilization by the elderly have not been properly emphasized. This paper stresses that "the elderly" are not, as is often assumed, very high users of all types of health services. Their use of physician services is only somewhat higher than that of other age groups. Although "the aged" may appear to use a disproportionate amount of hospital care, the great majority of elderly, even the very elderly, are healthy and infrequently hospitalized. This paper illustrates how current health care utilization statistics tend to magnify misconceptions about such utilization among the elderly.

If the patient is assumed to be the primary determinant of patterns of health care utilization, an increase in the numbers of elderly would be expected to translate directly into increased demand for services. Data showing peculiar variations in health care consumption across small geographic areas, however, challenge this assumption, hence the second focus of this paper: "Whose demand?"

Method. — Data for these analyses are drawn from two ongoing research projects, the Manitoba Longitudinal Study on Aging (Roos & Shapiro, 1981) and the Manitoba Study of Common Surgical Procedures (Roos & Roos, 1983).

The Manitoba Longitudinal Study on Aging (MLSA) is fully described elsewhere (Mossey et al., 1981). Briefly, the MLSA merged data from extensive interviews with a randomly selected, province-wide sample of just over 4,800 elderly conducted in 1971 (Manitoba Department of Health and Social Development, 1973) with claims documenting these individuals' health care utilization over an eight year period (1970–1977). The claims are those filed routinely by hospitals and physicians with the government agency responsible for administering the universally insured medical and hospital services in the province. The medical and hospital data have also been described elsewhere (Roos et al., 1979), and all tests to date suggest that the data base provides a reasonably accurate, reliable, and valid representation of health care utilization. The absence of deductibles or copayment, coupled with the physician's natural inclination to claim for service, limits the likelihood of underreporting. Regular audits asking patients to confirm the receipt of services and the monitoring of physician patterns of practice profiles, on the other hand, discourage over-

[1]Earlier versions of this paper were presented at the Statistics Canada Conference on "Statistical Implications of Emerging Health Issues and Outlooks," Ottawa, March 1982 and at the Canadian Association of Gerontology Meetings, Winnipeg, November 1982. This research was supported by grant numbers 6607-1157-46 and 6607-1197-64 from the Research Programs Directorate, Health and Welfare Canada, and a Career Scientist Award 6607-1001-22 to the senior author and a Health Scholar Award 606-1114-48 to the third author.

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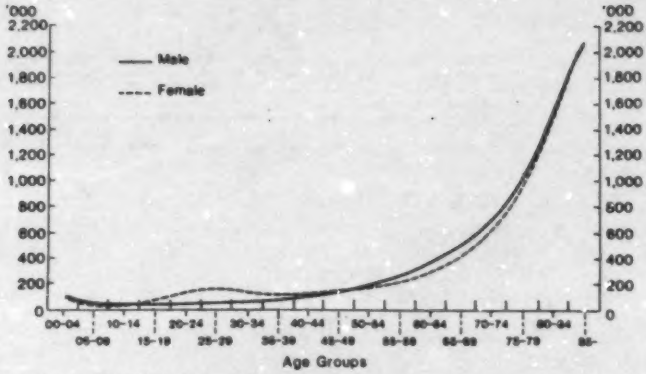

Figure 1. Days of care per 100,000 population by sex and 5-year age groups, 1977
Note: From Statistics Canada, Hospital Morbidity, 1977. Catalogue No. 82-206. (Health and Welfare Canada, Ottawa, 1980), 1980, p. 16 (fig).

reporting of services. Since Manitoba residents are reimbursed for physician visits and hospitalizations which occur outside the province, the elderly also have every incentive to report any out-of-province utilization to the health commission.

The Manitoba Study of Common Surgical Procedures uses the same claims data base to focus on provincial surgical practice patterns as well as upon nine common procedures, including those primarily performed in the elderly population — cataract surgery and prostatectomy. As a part of this research, a probability sample of the population 25 years and older (stratified by age, sex, and urban versus rural residence) was drawn from the 1974 MHSC master registry. Hospital and physician visits for this group (n = 8,000) were summarized and pivoted around a July 1, 1974 date. Only individuals alive and covered by the provincial insurance system during the four-year period (1972–1976) for which utilization was examined (79%) were included in the analysis.

Table 1. Patterns of Physician Visits (Home, Office, Outpatient, or Emergency Room) By Age (1974–1976)

Number of Visits	Age of Individual 25–44	45–64	65+
Mean number of visits	3.5	4.3	5.2
Number of visits in year (percentage in each category)			
0	21	20	18
1–2	34	27	21
3–6	29	30	31
7–13	12	17	21
14+	3	6	8
Number*	1,503	1,747	3,088

*Percentages are based on the sample weighted to reflect age distribution of Manitoba population.

Which Aged?

Our analyses of the Manitoba data suggest that assuming that "the aged" use large amounts of health services is inappropriate. First of all, the elderly do not make disproportionately large numbers of physician visits. Although this population is a less healthy one than younger age groups by any measure used (mortality rates, chronic conditions, etc.), the elderly make only approximately 1.7 more physician visits a year (5.2 mean visits per year for persons aged 65 and over versus 3.5 per year for those aged 25 to 44) than the group aged 25 to 44 and only 1 more visits per year than the group aged 45 to 64 (Table 1). Approximately one-fifth of all age groups, including the elderly, do not visit a physician at all during a 1-year period. Furthermore, although hospitalization rates increase dramatically in the very advanced age group, this is not true for rates of physician visits. The physician contact rate (out of hospital) among the oldest group, aged 85 and older, was not significantly higher than that of 65- to 69-year-olds (Roos & Shapiro, 1981). The rate at which the elderly are referred to medical consultants is even lower in Manitoba than the rate of consultations in the rest of the population (Roos & Shapiro, 1981). Clearly, in this important area of health care expenditures, the elderly are not large consumers.

The elderly are, of course, large consumers of personal care home and home care services. No one disputes the fact that most nursing home beds are occupied by elderly patients and that nursing home costs and utilization have escalated sharply in recent years (Scanlon, 1980).

Manitoba has had a provincially insured nursing home program since 1973 and a generous supply of nursing home beds. For example, in 1976, 6.5% of Manitoba's elderly lived in nursing homes compared with approximately 5% of the U.S. elderly (Kane & Kane, 1978). Yet, despite this fact only a very small percentage of the elderly will ever enter a nursing home. Of approximately 3,300 elderly (aged 67 and over) interviewed in the MLSA, only 8% were admitted to a nursing home in the subsequent 4-year period. Even if we focus on the very elderly, those 85 and older (313), only 24% were admitted to nursing homes over the same period. In fact, during these 4 years an elderly person in the sample was more likely to die having never been admitted to a nursing home than to be admitted (18% of the community residents aged 65 and over had died and 31% of those aged 85 and over had died).

However, most attention has been focused on the elderly's use of acute hospitals. Individuals aged 65 and over clearly do consume large numbers of hospital days, both on an absolute basis (Figure 1) and on a per capita basis, but the Manitoba data suggest that less than one-quarter of the elderly are hospitalized in any given year (Roos & Shapiro, 1981) and that a much smaller proportion (5%) consume almost two-thirds (59%) of the hospital days used by the elderly in a 1-year period (Roos & Shapiro, 1981).

The MLSA tracked hospital usage of a cohort of elderly over a five-year period. A very sizeable group (42%) was never admitted to the hospital (Table 2). Most of those admitted one or more times in the ensuing 5-year period tended to accumulate very few hospital days; again, a very small group of elderly (2%) used 20% of the days. Table 2 focuses only on acute hospital stays, those lasting 30 days or less in an "acute" hospital. A similar pattern was observed when both acute and chronic hospital stays were examined (4% of the elderly consumed 43% of the acute and chronic hospital days). The analysis was also repeated for the very elderly, those aged 85 and older; this group has the highest hospitalization rate and the largest projected growth rate. The patterns were generally similar. Thirty-five percent of the very elderly were not admitted to hospital in the subsequent 5-year period, 4% of this group accounted for 32% of the acute hospital days used by all those aged 85 and older, and 9% used 57% of the acute and chronic hospital days.

Why do most discussions of health care usage by the elderly mask the fact that most elderly, even most of the very elderly, are healthy and low, infrequent users of acute and chronic hospitals? The single most important reason is probably that most statistics are based on hospital discharges which, by definition, focus on usage rather than nonusage. Without individual identifiers, discharge data are difficult to turn into tables which capture the skewed nature of hospitalization patterns. In the U.S., inferences about this can be made from the Health Interview Survey (from such questions as "have you been hospitalized in the previous two weeks?"). But such data are difficult to use in making projections, responses depend on memory, and the method of obtaining information is expensive.

A number of alternative, but not necessarily mutually exclusive, strategies might reduce some of the disadvantages arising from the way data are currently analyzed and reported. One strategy, using only existing hospital discharge information, would be to avoid the use of a gross length of stay figure. Breaking "length of stay" into short stays and long stays provides a very different perspective on hospital utilization, particularly for the elderly population. For example, a previous analysis (Shapiro et al., 1980) using a simple average length of stay measure suggested that, during the 1972–1976 period, all younger age groups' lengths of stay were decreasing while mean lengths of stay for those aged 65 and over were increasing (by 15% for those 75 and over). When average days of stay were analyzed according to those stays over 90 days and those stays under 90 days, however, the very long stays showed a dramatic increase while the average length of the under 90-day stay dropped by 1 day for each elderly age group. The over 90-day average length of stay increased from 117 days in 1972 to 218 days in 1976 for the oldest group (75+ years).

Another possibility would be to develop individual-based utilization figures wherever claims data, such as those available through Medicare, permit tracking individuals through time. Alternatively, projections could be made from hospital discharge information using individual-based data available from such sources as the Manitoba Studies. For example, Table 3 suggests that both the percentage not hospitalized in a given year and the mean number of hospitalizations of those hospitalized tend to be quite stable over time within given age groups.

Table 2. Patterns of Acute Hospitalization 1972–1976 For Those Elderly Interviewed in 1971

Total Days Hospitalized Over Five-Year Period	Percentage of the Elderly Population	Percentage of Total Days Consumed by Group
0	42	0
1–14	20	6
15–29	14	12
30–89	17	37
90–179	5	24
180+	2	20
Number	4,553	116,338

Whose Demand?

Will the patterns of health care utilization by the elderly in the next decades be simply a function of their increasing numbers? This straightforward projection makes sense if we assume that no major technological changes will take place and that the elderly themselves determine which and how many health care resources are consumed. This latter assumption, that the patient and his or her medically defined "needs" directly determine hospitalization and surgical patterns, is being increasingly challenged. In a recent review of the literature on small area variations in health services delivery, Wennberg and Gittelsohn (1982) have found wide-ranging variations in consumption of hospital days and surgical ser-

Table 3. Stability of Individual Based Utilization Statistics Over Four-Year Period

	Age of the Individual in 1974				
	25–44	45–64	65–74	75–84	85+
Percentage not hospitalized in given year					
1972–1973	88	89	84	80	77
1973–1974	90	89	86	80	73
1974–1975	88	88	84	81	74
1975–1976	89	88	81	76	75
Mean number of hospitalizations of those hospitalized					
1972–1973	1.5	1.1	1.4	1.6	1.4
1973–1974	1.3	1.4	1.4	1.6	1.5
1974–1975	1.3	1.3	1.4	1.6	1.5
1975–1976	1.2	1.1	1.5	1.6	1.5
Number*	1,503	1,747	1,668	1,121	299

*Percentages and means are based on the sample reweighted to approximate the distribution of each age group in the population. The cohort was defined as of July 1, 1974; each year's data represent the cohort's utilization during that period.

vices across countries, within countries, and within states and provinces.

Large variations in rates of surgery across Canada have been demonstrated, and these variations also appear for those procedures performed primarily on elderly patients. For example, in 1976 and 1977 Saskatchewan had a transurethral prostatectomy rate approximately 10 times that of Prince Edward Island (Statistics Canada, 1980a, 1981). Stockwell and Vayda (1979) have also shown dramatic intraprovincial variations within Ontario, with one county's residents undergoing colectomy seven times as frequently as another county's residents. Wennberg's literature review concludes that it is difficult to assume that patient demands are solely responsible for producing these patterns. He believes that physician practice patterns, how disease is diagnosed, and what treatment (if any) is proposed explain at least as much of the variation in health services delivery as the characteristics of an area's population (the potential patients).

These variations can have a tremendous multiplier or moderating effect on how the increase in the elderly population will affect health care consumption patterns. For example, Wennberg et al. (1980) have estimated that a high surgery use strategy for seven common procedures (based on costs in high rate American areas) adopted across the U.S. population would cost $6.7 billion per year while a low use strategy would cost only $2.4 billion (in 1975 dollars).

Surgery is not the only type of health care resource whose usage varies markedly across small areas. Gornick (1977) reports marked regional variations in the use of acute hospitals by Medicare patients. North Dakota's hospital discharge rate was 425.6 discharges per 1,000 enrollees, almost twice that of Maryland at 235.9 discharges per 1,000.

Our ongoing research focuses on variations in health care consumption by the rural elderly population of Manitoba. We have defined 56 hospital areas in rural Manitoba. Winnipeg residents, comprising slightly over half the population, were excluded because service areas in a major metropolitan area are more difficult to construct. For rural Manitobans being operated upon in Winnipeg, however, this surgery was attributed back to their own area and was used to calculate that area's surgical rate. Small areas were defined using the criterion that at least 30% of the residents hospitalized in 1971 were admitted to the hospital within their home area. For these areas the median percentage of patients hospitalized within that area facility was 57.3%. Most areas (based on rural municipality boundaries) contained only one hospital, but some had two located in adjacent towns so that the catchment areas overlapped significantly.

Table 4. Surgical Rates for the Elderly Across 56 Hospital Areas — 1971–1972

	Lowest Rate	Highest Rate
Individuals undergoing surgery per 1,000 elderly	53	144
Elective surgical rate per 1,000 elderly	18	57
Complex surgical rate per 1,000 elderly	14	54
Cataract surgery rate per 1,000 elderly	2	13

Table 4 shows the range in surgical rates across these hospital areas. During the 2-year period 1971–1972, almost three times as many elderly individuals in the high rate areas underwent surgery as in the low rate areas (the surgical rate in the lowest area was 53.3 per 1,000 elderly versus 144.2 in the highest). This same pattern of variation is maintained regardless of whether one focuses on all surgery, on only elective surgical procedures, or on complex surgical procedures. (Complexity is defined using the hernia equivalent index, a measure developed by Hughes (1972) assigning weights to each surgical procedure based on the California Index of Relative Values. By restricting the analysis to procedures having a hernia equivalent of 2.0 or greater, the complex surgery measure counts such major surgery as vagotomy and pyloro-

plasty, bilateral nephrectomy, etc.) Even cataract surgery rates varied from 3 per 1,000 elderly in the lowest rate areas to 13 per 1,000 in high rate areas.

The surgical practice patterns across these 56 areas also varied dramatically. In at least one area, fully 68% of all surgery on elderly patients (above a minimum level of complexity) consisted of one of seven "elective" procedures, in another area only 28% of the surgery consisted of these seven procedures.

Researchers focusing on small area variations are generally skeptical of strictly patient-based explanations. As discussed below, per capita rates of surgery (and hospitalizations) remain remarkably stable from year to year, but no clear relationship has been found between the health characteristics of a population (as measured in interviews with the elderly) and surgical rates (Roos & Roos, 1982b). This was true even when specific questions relating the prevalence of eye or vision problems to rates of cataract surgery were examined. A moderate relationship between ethnicity, income, and surgical variations was found; areas with a large percentage of elderly whose origins were Canadian, English, or American and areas with a relatively high proportion of educated elderly had higher surgical rates.

However, physician behavior would seem to make an independent contribution to patterns of health care consumption. Wennberg (1979) has suggested that areas have surgical signatures which remain relatively constant until a physician enters or leaves an area. The Manitoba data also suggest that physician behavior underlies year-to-year consistency in the amount of surgery performed in rural hospital areas. For 1974 and 1975, overall rates of surgery performed in our small areas correlated at a level of .82. Year-to-year product moment correlations for rates of surgery performed within the area and rates for that performed outside it (primarily in tertiary centers) were even higher; the correlations were .90 and .89, respectively. Surgery for an area's residents was separated into that performed by "permanent" physicians, operationally defined as those physicians having the same home area for 5 years. These physicians typically perform about 70% of the surgical procedures done in their home areas. The consistency of their year-to-year workloads (autocorrelations always over .85 and generally over .90) underlie the correlations found for small area utilization (Roos, 1983).

Discussion

This research has focused on the fact that "the elderly" are not necessarily high users of health care services. In fact, despite their poor health status, the elderly's rate of physician contact is similar to that of younger groups, and their rates of referral to specialists are even lower. The findings concerning physician contact rates are similar to those reported for the U.S. elderly (Roos & Shapiro, 1981) and do not support the commonly held belief that advanced age dramatically increases the consumption of all types of health care. However, these contact rates also lead one to wonder whether more vigorous ambulatory physician intervention, perhaps with referral to appropriate experts, might help to protect the elderly from long and repeated hospitalizations.

This paper has also focused on utilization of hospital and personal care home services and has demonstrated that most elderly require few of these expensive health care resources. This is important because of the negative image that publicity for using on the increasing numbers of elderly and their heavy use of health care resources has created. This negative image undoubtedly affects how the elderly view themselves and are viewed by their families and by health professionals.

Demonstrating that a small group of elderly accounts for the large proportion of hospitalization and nursing home usage does not change the fact that individuals over 65 years of age are occupying beds in these institutions, but these data on patterns of the elderly's utilization do have important policy implications and should help to alter the mental images of the elderly population. Since a small group of the elderly accounts for such a disproportionate usage of the health care system, interventions directed toward this group, such as providing intensive support services, geriatric referral services, and so forth, would seem feasible. Also, and importantly, the observed usage pattern suggests that such efforts could have a substantial impact.

Utilization depends not only upon patient characteristics but also upon physician behavior. Physician practice patterns influence which and how many health care resources are consumed by the elderly. Although the elderly initiate most ambulatory physician visits, the physician largely determines whether an individual will be admitted to a hospital. A preoccupation with the influence that increasing numbers of elderly will have on the health care system should not mask the potentially even greater impact that the increasing physician supply in North America is likely to have on health expenditures during the next decade. Despite multiple manpower reports suggesting that the supply of physicians, particularly of surgeons, is sufficient or tending towards a major surplus, there has been no indication that the production of physicians has been altered (Moore, 1982; Williams, 1981, 1982).

In summary, the "looming crisis" in health care delivery which is expected from the aging of our population should be rethought. The crisis, if one evolves, may be created by ignoring the real needs of a relatively small number of elderly who are presently using very extensive services. Furthermore, this "crisis" may be intensified both by the large increase in physician numbers expected during the next decade and by the large amount of physician discretion in determining the services that the elderly and other population groups receive.

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